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Doing serodiscordant intimacy in the era of HIV biomedicalisation: A qualitative investigation of the lived experience of gay and bisexual men in serodiscordant relationships in the UK

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Abstract

HIV 'treatment as prevention' (TasP) is a biomedical concept in which antiretroviral drugs are deployed to prevent HIV transmission. TasP originated as an epidemiological concept created in order to tackle the HIV pandemic but is expected to have transformative potential for people in mixed HIV status (serodiscordant) relationships. Hailed in medical circles as a 'game changer', TasP has been framed in the 'U=U' community discourse as providing certainty about the lack of transmission risk and as an opportunity to tackle stigma. I argue that although TasP was produced through studies of people in serodiscordant relationships, it neglects the intimate contexts in which it operates. Serodiscordant relationships have been constructed as troubled sites of transmission risk. In light of the biomedical transformation of HIV prevention, these risk-centric conceptions have been contested as couples draw on TasP to realise new forms of serodiscordant intimacy. This thesis provides an examination of how gay and bisexual men in serodiscordant relationships practice intimacy and how these practices are structured through biomedical and social influences. It presents the findings of a study of the lived experience of serodiscordant relationships in the UK drawing on a phenomenologically informed thematic analysis of data generated in individual (n=28) and couple interviews (n=6). Participants incorporated biomedical practices, such as taking treatment, into their everyday practices of intimacy and engaged in emotion work to establish a sense of normality. They engaged with biomedically transformed risk and the relationality of serodiscordancy to redefine 'safer sex' and ideas of responsibility. Participants managed their serodiscordant identity in order to deal with stigma, selectively engaging with others outside their relationship. In contrast with the certainty that is central to community articulations of the meanings of TasP, uncertainty underpinned participants' everyday experiences of serodiscordancy. This thesis contributes to sociological literature on intimate relationships to understanding of how biomedical transformations more generally are lived. By combining biomedicalisation and intimacy theories with a focus on the everyday, it provides a novel framework through which to examine serodiscordancy.

Dedication and acknowledgements

This has been the hardest thing I've ever done. I'm very grateful for the love and encouragement from friends and family over the past four years. I couldn't have finished this without the guidance and wisdom of my supervisors, who expertly steered me through the inevitable obstacles along the way. Most of all, I couldn't have done this without Grev, who put up with and stuck with me through the difficult bits, nor without Dave, who kept me company during the hours at my laptop.

Above all, none of this would have been possible without the men who so generously shared with me some of the most personal and private details of their lives, to whom I dedicate this thesis.

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1. Introduction

*If you knew when you began a book what you would say at the end,
would you have the courage to write it? What is true for writing and
for love relationships is true also for life. The game is worthwhile
insofar as we don't know what will be the end
Foucault, Technologies of the Self (1988)*

This thesis sets out the findings of four years of research into the intimate practices of gay and bisexual men in serodiscordant relationships living in the UK at time when both the experience of living with HIV and HIV prevention are being transformed through biomedical processes. Although it was inevitable that PhD research would eventually conclude with this thesis, as the quote above suggests, the data, theories and arguments that it consists of were not at all clear at the beginning and, indeed, have in some cases only come together through a number of iterations. It also provides an insight into twenty intimate relationships, each on its unique trajectory as participants and their partners navigate complex and intersecting emotional, social and biomedical discourses. As with Foucault's focus on 'the game', above, rather than 'the end,' the organising principle of this thesis, that of 'doing serodiscordancy' explores the way in which participants negotiate this terrain through their everyday practices. This first chapter sets out the rationale that underpins the research and how, by bringing together theories of biomedicalisation and intimacy it will contribute to the existing literature on serodiscordant relationships. It also provides a personal account of how I came to carry out this project and how my engagement with the research question has changed over its course. Finally, it looks ahead to the rest of the thesis and briefly summarises the content of each chapter.

In the nearly 40 years since the HIV epidemic in Europe and the USA began, significant progress has helped to transform what was a generally fatal infection into a long-term health condition (Singh, Dunford and Carter, 2001; Swendeman, Ingram and Rotheram-Borus, 2009). In the most recent of these developments, the potential of antiretroviral treatment to not only protect the health of the person taking it, but also prevent sexual transmission (known as ‘treatment as prevention’ or TasP), has been hailed as potentially transformative in tackling the epidemic (Cohen *et al.*, 2011; McCormack *et al.*, 2015; Molina *et al.*, 2015; Daar and Corado, 2016; Rodger *et al.*, 2016, 2019). Not only an epidemiological phenomenon, TasP has the potential to transform the experience of people living with HIV and their HIV negative partners and is anticipated to reduce fear of transmission and stigma (Persson, 2016; Prevention Access Campaign, 2017). However it has been argued that the social impact of these new technologies has been neglected and critical social science research that involves people living with HIV is needed to complement and problematise biomedical implementation (Keogh and Dodds, 2015; Young, Flowers and McDaid, 2015; Keogh, 2016; Young *et al.*, 2019). Serodiscordant relationships (a primary relationship in which partners have or believe they have different HIV antibody statuses) have attracted considerable social scientific and medical attention, primarily as sites of behavioural intervention to mitigate HIV transmission and, latterly, as a social phenomenon in their own right. However, as I will argue, the prominence of biomedicalised discourses of TasP and its communitarian equivalent, U=U (see Chapter 2, *Biomedical HIV prevention*) invites a critical reappraisal of serodiscordancy that engages with everyday experiences of intimacy that these discourses neglect.

Research rationale

Research into gay and bisexual men’s sexuality in response to the HIV epidemic was initially orientated towards describing patterns of sexual behaviour in order

to understand and manage HIV transmission risk (Phellas and Coxon, 2012). A body of work carried out in the social cognitive paradigm has sought to explain sexual risk behaviour observed in serodiscordant couples and devise educational and behavioural interventions to reduce its incidence (see Chapter 3, *Serodiscordancy and risk*). This approach has been criticized for overemphasising individual responsibility, reducing the complexity of interpersonal relationships and ignoring the interplay of diverse social determinants of behaviour, as well as establishing a framework in which notions of 'safe' and 'risky' behaviour have been transformed into moral judgements that have contributed to social exclusion of gay and bisexual men and undermined HIV prevention efforts (Flowers, Duncan and Frankis, 2000; Flowers and Duncan, 2002; Adam, 2005; Davis, 2008; Adam, 2016).

Studies carried out before the advent of TasP focused on the challenges partners faced in balancing relationship intimacy with managing HIV risk. In doing so, this literature constructed them as sites of tension and compromise. More recent studies have suggested that TasP is altering the balance between risk and intimacy and is therefore supporting new, more open forms of serodiscordant intimacy (Persson, 2016). These changes in relationship intimacy can be understood through theoretical framework of biomedicalisation (see Chapter 3, *Conceptualising biomedical transformations*). This theory describes how the implementation of biomedical developments influences, and is in turn influenced by, social processes. Studies of the views of people living with HIV about TasP have highlighted how individuals' past experiences, current embodied beliefs and future desires interact to mediate its impact (Persson, 2013b; Bourne et al., 2015; Young, Flowers and McDaid, 2015; Keogh, 2016, 2020). This research draws on and extends the qualitatively orientated research programme that has worked to explicate the experiences of serodiscordant relationships (see Chapter 3, *Serodiscordancy in context*).

This research also draws on a separate literature concerned with intimacy in relationships more broadly (see Chapter 3, *Engaging with intimacy*) which provides an additional theoretical lens through which to examine these relationships. In particular, studies of families and long-term relationships have drawn attention to the importance of embodied practices in constituting intimacy (Gabb, 2008; Gabb and Fink, 2015a). However, this literature is seldom brought to bear in empirical analyses of HIV and relationships. Therefore, this study aims to redress this by advancing an investigation of the lived experience of serodiscordant relationships in the era of TasP with a focus on everyday intimacy and the biomedical. The intention of this approach is to explore the multi-dimensionality of serodiscordant relationships by considering everyday practices of intimacy and the meanings participants ascribed to them.

By focusing primarily on what participants in the study are doing in the everyday, I aim to contribute to the sociological literature on personal relationships in relation to theories of intimacy. I will explore how participants 'do' their relationships and how these practices are structured through a range of biomedical and social influences. This focus on 'the everyday' has the capacity to make a valuable and nuanced contribution to understandings of serodiscordant relationships *as they are lived* and at time of continued biomedical transformation. Engaging with this 'intimate knowledge' (Raffles, 2002) and examining lived experience in this way will also contribute to understanding of how biomedical transformations more generally are lived (Keogh and Dodds, 2020). As Flowers (2001) points out, historically epidemiological and social scientific understandings of HIV risk have often lagged behind gay and bisexual men's practices. In focusing on how serodiscordant couples are practicing their relationships at a time of transformation of understandings of HIV risk, this research can therefore help to inform future research and policy.

My motivation and position

In this section, I anchor the thesis in my personal context. I will discuss how I came to this topic and research question and how my position has evolved through the research. Reflexivity is a key component of my research approach and I explore its methodological underpinnings later in this thesis (see Chapter 4, *Reflexivity*). I first considered studying the experience of serodiscordancy when I was working on a medical and community HIV educational programme sponsored by a pharmaceutical company. The meeting I attended brought together HIV physicians and representatives of advocacy groups from across Europe to discuss the data from HIV Prevention Trials Network study 52 (HPTN-052) (Cohen *et al.*, 2011). Although the concept of TasP had been advanced through the work of a group of physicians in Switzerland, the results from HPTN-052 were the first from a large scale randomised clinical trial that supported the idea that treatment could prevent sexual transmission of the virus. Both physicians and advocacy group representatives were excited by the possibility that this 'proof' afforded. Much of the discussion focused on the impact that being uninfected would have on a person living with HIV and how this could reduce or even prevent wider stigma directed against people who were HIV positive. At this stage, the data from the study suggested a significant reduction in the rates of transmission, with a 96% reduction in linked transmissions in the group offered immediate HIV treatment, compared with those who delayed treatment. Despite the excitement and optimism during the meeting, there were also those who were concerned that TasP as a concept was not yet supported by enough evidence, particularly as HPTN-052 was a study of heterosexual couples in Africa. Several voiced reservations about the reliability of an undetectable viral load in the blood stream as a marker of uninfectedness through sexual routes. Others discussed the implications of initiating treatment for the benefit of others, rather than the individual (Krellenstein and Strub, 2012; Guta, Murray and Gagnon, 2016; Lloyd, 2018).

At the same time, I was volunteering at a sexual health clinic providing advice to gay and bisexual men. One service user was concerned that he had been exposed to HIV through contact with semen on a cut on his finger. We discussed the main routes of HIV transmission and reviewed national guidelines on the provision of post-exposure prophylaxis (PEP) in order to reassure him that he did not require PEP even if his sexual partner was HIV positive. During our discussion he later mentioned that he was concerned that he had been exposed during sex with his partner, who was HIV positive. We discussed the 'Swiss Statement' (Vernazza *et al.*, 2008), which at that time was the most prominent position on the relationship between undetectability and uninfectedness. He also told me how most of the time his partner's status didn't bother him, although he occasionally experienced moments of concern, such as the incident that brought him to the sexual health clinic. He also said that although he tried not to show it when he was worried, it was as if his partner was looking out for subtle signs; even the slightest pause or falter during sex could lead to his partner becoming upset. It was this insight into the everyday lived experience of serodiscordancy which first fired my curiosity about how TasP might influence the emotionality of those experiences. I also wondered how individuals might apply a complex population-based statistic to their everyday life and how different, non-commensurate conceptions of risk might apply.

Having decided to undertake a PhD in order to pursue my interest in sexual health and intimacy, I developed the proposal for this research. As I explored the unmet needs for research, I moved further from a question that focused on the understanding and application of data supporting TasP through different conceptions of risk towards one that took into consideration the broader experience of serodiscordancy. Through the process of reviewing the literature and developing a theoretical framework, my personal position shifted away from the technical, biomedical and psychological towards the sociological. Taking a lead from the studies of serodiscordancy in Australia led by Asha Persson, in

particular her call to move away from research which positioned these relationships as inherently troubled or risky, I moved towards a phenomenologically orientated position. This led me to frame my research questions (see next section) in terms of the lived experience of serodiscordant relationships and relationship practices. Eschewing discourses of risk and risky behaviours, which I increasingly saw as stigmatising, I hoped to provide a more nuanced account of serodiscordancy in its own terms. In the UK, the two groups most affected by HIV are gay and bisexual men and heterosexual Black Africans (Kirwan et al., 2016). Although TasP has been shown to apply to both heterosexual and homosexual sex, the experiences of these two groups is likely to be different (Bourne, Owuor and Dodds, 2017; Persson and Hughes, 2017). Given my background and prior experience, this project focuses on the experiences of gay and bisexual men.

Although I have adopted an epistemological position that holds that objectivity is ultimately not achievable (see Chapter 4, *Research approach*), taking inspiration from phenomenology encouraged me to attempt to recognise and 'bracket' my relationship to the research (Van Manen, 1990, 2007; Finlay, 2011). Yet, this personal reflexivity may only capture part of the researcher's influence on an investigation and should also be complemented with methodological and epistemological reflection (Braun and Clarke, 2019). During analysis, while drafting an article on the experience of conducting this research (see Appendix G), I realised that my awareness of the potential for this research to tackle stigma (Plummer, 1995; Persson, Ellard and Newman, 2016) had diverted me from an exploratory investigation of lived experience. Instead I had become seduced by an attempt to answer the question, '*does HIV matter in relationships anymore?*' In seeking to find a definitive position in ongoing debates, I had become entangled in the same web of biomedical and social influences that my participants were themselves navigating. Recognising I had fallen down this 'rabbit hole' helped re-orientate me to the research question and led me to

adopt the term 'doing serodiscordancy' to refer to the totality of participants' practices and emotion work (Hochschild, 1979). Advancing an account of serodiscordancy in this way has supported a critical engagement with community, biomedical and social discourses. In addition, bringing together the range of practices and work under a single concept helped to shift the focus of analysis away from a comparison of the different approaches deployed by individual participants. This risked becoming an evaluation of participants' practices, particularly in light of the emergence of the discourse of U=U and an increasingly prominent articulation of how serodiscordant intimacy could (and *should*) be practiced (see Chapter 2, *Biomedical HIV prevention*). Instead, I use 'doing serodiscordancy' as a lens through which to focus on how participants draw on their past experiences and current context in order to deploy a range of practices at different times and in different settings.

Ironically, despite an aim at the outset to focus on everyday experiences of serodiscordant intimacy and get away from a narrow focus on transmission risk, one of the conclusions of this research centres on the gap between ongoing lived experience and scientific data. This uncertainty underlies many of the concerns participants had and the 'spectres' of HIV that occasionally haunt their day-to-day lives. Participants describe relationships in which stigma and concerns about HIV transmission are largely absent. However, throughout this thesis I trace the influence of persistent HIV stigma and the normative value placed on an HIV negative status and how this continues to shape serodiscordant intimacy. In advancing these conclusions I hope to illuminate the details of lived experience of serodiscordancy in the era of TasP, but also to advance a framework that facilitates examination of other intimacies that have been transformed through biomedicalisation.

Research questions

The research questions that underpin this research have been formulated to shape an enquiry that examines serodiscordancy from the perspective of everyday intimacy to provide a critical foil to biomedically inflected conceptions of serodiscordancy.

- What is the lived experience of gay and bisexual men in serodiscordant relationships?

By focusing on lived experience, this research takes the everyday as the basis of its analysis. As I will outline in Chapter 4, it also invites engagement with phenomenologically informed methods of data generation and analysis.

- How is serodiscordancy experienced within the relationship?

Questioning how serodiscordancy is experienced helped shape the findings of this research and the experiences of serodiscordancy in three different settings are outlined in Chapters 5, 6 and 7 of this thesis (see next section).

- What 'practices of intimacy' do participants use to support their serodiscordant relationship?

As I have outlined above and will argue further in Chapter 3, adopting a practices approach to examining intimacy brings to light ways in which participants engage with serodiscordancy in the context of giving and receiving care, expressing their closeness to each other and in conflict.

- How have biomedical and pharmaceutical developments shaped partners' experiences and practices in serodiscordant relationships?

By considering the influence of social and biomedical discourses in shaping participants' practices, this question helped to bring into focus the everyday work of serodiscordancy and how participants structured and engaged emotionally with their relationship.

Thesis overview

The following chapter provides an overview of the epidemiology of HIV in the UK and examines the range of social and biomedical responses to the HIV epidemic over time, with particular focus on the development of TasP as an epidemiological concept and, latterly, its application to individuals and the emergence of the community discourse of U=U.

Chapter 3 reviews the published literature on serodiscordant intimacy, exploring two strands of research located in differently orientated disciplinary paradigms. It then sets out a theoretical framework for subsequent chapters, bringing together theories of biomedicalisation and a separate literature that focuses on relationship intimacy.

Chapter 4 sets out the epistemological and methodological foundations of the research. It also provides overviews of how data were generated, the research participants, and a discussion of ethical considerations. It concludes with a detailed account of the phenomenologically informed thematic analysis used to explore data and a reflexive exploration of the research.

Chapters 5, 6 and 7 consist of the findings from the qualitative analysis. Chapter 5 focuses on participants' everyday intimate practices and the emotional labour that they deployed in their relationships. It considers participants' accounts of an everyday in which HIV was largely absent.

Chapter 6 explores the role of sex in participants' relationships and how they drew on transformations of risk wrought by TasP to negotiate their sexual practices and redefine boundaries of (ir)responsibility.

Chapter 7 turns to participants' discursive practices and how they talked about serodiscordancy. This includes when they first encountered serodiscordancy in their current relationship as well as how they draw on TasP and U=U to engage in boundary work, bringing some into closer intimacy and excluding others.

Chapter 8 is the conclusion and brings together findings from the previous three chapters, relates them to existing literature and considers their implications for theory and for practice. It also sets out future directions for further research.

A note about use of language and terminology

In this thesis, I have followed Public Health England's convention of referring to 'gay and bisexual men' in preference to 'men who have sex with men' (or MSM). As this is a sociological rather than epidemiological analysis, using these terms emphasises the importance of social identity in lived experience and in particular relationships to others, rather than focusing on sexual activity per se. It also reflects participants' self-identification as gay. Although there may be commonalities, there are likely to be significant differences in lived experience for those who identify their sexuality in other ways and further research into the experience of serodiscordancy among different sexual identities would complement this study (see Chapter 8).

The stigmatised history of HIV/AIDS has led to the deployment of language that is itself stigmatising (<https://hiveonline.org/language-matters/>). I recognise the importance of appropriate and sensitive language use in this thesis. The recognition of AIDS as a syndrome before the discovery of HIV, the causative agent led to the terms being used together. However, following the advent of effective therapies, AIDS has become a rare and often temporary state from which people living with the virus receiving appropriate treatment recover, leading to a move away from using the term AIDS as a diagnosis on its own (instead preferring stage-3 HIV infection or an AIDS-defining illness). Although the term HIV/AIDS is still used in the global response, its use is sometimes flagged as potentially confusing. Except in historical contexts, I will refer to HIV and HIV serostatuses. Similarly, although serodiscordancy is a term that is associated with negative connotations (implying a mismatch or *discord* within a relationship), I use it in this thesis because of its accepted use within the existing literature and its convenience as a shorthand. I recognise the existence of alternative terminology (such as *mixed-status*, *serodifferent* or *magnetic*) which capture the essence of serostatus difference with less semantic baggage. When recruiting for the study, I avoided terminology entirely and deployed the description 'a man in a relationship with a man who has a different HIV status' (see Chapter 4, *Participants*)

2. Context

For much of the last two decades, many surviving gay men of all antibody statuses were reduced psychologically, spiritually, and sometimes physically to dry bone, languishing in the hot sun, awaiting destruction or revival... The dry bones have had life breathed back into them and now stand as giant tribes, eager to move forward, awaiting the new era

Eric Rofes, Dry Bones Breathe, 1998, p28

Writing in 1998, two years after the availability of HAART began to reduce rates of AIDS-related deaths, Eric Rofes explored the emergence of what he called 'post-AIDS' cultures among gay and bisexual men living in the United States of America (USA) (Rofes, 1998). He examined how the changes begun by the availability of effective treatments were being translated into new identities and new possibilities. Crucially, he focused on how social lives and cultures that had become dormant or hidden were being revived by gay and bisexual men who had lived through the AIDS crisis, but also how they were being transformed by younger men, entering these social contexts without direct experience of AIDS. Although at the time, the concept of a 'post-AIDS' gay culture was controversial, nevertheless Rofes sought to explore what the biomedical transformation meant for gay and bisexual men's lives. More than twenty years later, similar questions are being asked about what the biomedicalisation of HIV prevention through TasP and PrEP will mean for gay and bisexual men now and in the future (Race, 2018). This thesis seeks to explore how the biomedical transformations brought about by TasP shape the lived experience of gay and bisexual men in serodiscordant relationships. In order to be able to provide an account of these changes, it will first examine the context in which these changes are occurring. In this chapter I will provide context and background, including an overview of

HIV epidemiology and recent treatment and prevention policy in the UK. I will then turn to a summary review of the history of HIV prevention over a series of biomedical 'eras.' I include this both as a guide for readers less familiar with the social and biomedical histories of HIV/AIDS but also because one of the theoretical lenses I use to analyse the data generated in this study, biomedicalisation theory (Clarke *et al.*, 2003), emphasises that biomedical influences on 'the social' are articulated as transformations of pre-existing social patterns and structures. Furthermore, in interviews participants often contextualised their current experiences in relation to formative experiences of relationships and HIV. The biomedical and socio-cultural contexts are, therefore, core to personal biographies as they provide material and emotional backgrounds for later data. Historical experiences of HIV and of its transformation over time – both first-hand and vicarious – infuse participants' conceptions of their serostatus and of their relationships. Examining how these concepts emerged and transformed provides the bedrock for participants' accounts of their everyday lived experience and of ongoing change.

The epidemiology of HIV and serodiscordancy in the UK

HIV has caused a global pandemic, affecting more than 37 million people worldwide (UNAIDS, 2018). Without treatment the virus is usually fatal, attacking the immune system, gradually degrading its ability to fend off infections, leading to Acquired Immune Deficiency Syndrome (AIDS). The virus is transmitted through sexual intercourse, via sharing needles, blood transfusion and perinatally (Centres for Disease Control and Prevention, 2016). Infection with the virus has been associated with significant stigma and the epidemic has disproportionately affected already stigmatised and marginalised groups, such as men who have sex with men, intravenous drug users and sex workers (UNAIDS, 2018). HIV has been the focus of concerted behavioural, communitarian and latterly biomedical prevention programmes at national and

international levels as well as the development of community support and advocacy and campaigning organisations. Over the course of the last 30 years, significant progress has been made, reducing mortality and morbidity significantly and, for those able to access treatment, effectively transforming the virus to a manageable long-term condition. While a significant global communitarian and political response to the epidemic has resulted in a reduction in mortality, biomedical provision has often been concentrated in Western countries. Thus, although there have been global reductions in AIDS-related deaths, challenges remain and infection rates in many regions continue to rise ((UNAIDS, 2018).

In the UK, it is estimated that 103,800 people are living with the virus, of whom 49,800 are gay and bisexual men, constituting the single largest affected group. The majority of heterosexual men and women living with HIV in the UK are of black African ethnicity (O'Halloran *et al.*, 2019). There are no epidemiological estimates of the number of serodiscordant relationships globally (Mendelsohn *et al.*, 2015) or in the UK. Evidence from community surveys provides a range of estimates. A UK national survey (Auzenberg *et al.*, 2018) of people living with HIV in 2018 indicated that approximately 1 in 5 HIV positive gay and bisexual men responding to the survey were in a relationship where their main partner was HIV negative. A lower estimate was found in a survey of men who have sex with men in Scotland, where 18 of 1069 (1.7%) HIV negative men who had recently tested for HIV reported doing so because their partner was HIV positive (Frankis *et al.*, 2018). The UK survey also found that 40% of gay and bisexual men reported condomless sex with their partner in the previous 3 months. It found that condom use appeared to be influenced by the partner's serostatus as men (gay, bisexual and heterosexual) with an HIV negative partner were more likely to use condoms (28% all the time and 30% sometimes) compared to men with an HIV positive partner (13% all the time and 13% sometimes) (Auzenberg *et al.*, 2018).

Public Health England models estimate that approximately 7,500 of the 103,800 people living with the virus are undiagnosed. The number of undiagnosed cases of HIV has reduced in recent years, but there are geographical disparities in diagnosis rates, with more than twice as many undiagnosed people living outside London than inside it (O'Halloran *et al.*, 2019). The number of AIDS diagnoses and deaths has steadily declined over the past decade, with less than half the number of AIDS diagnoses in 2015 compared with 2006.

Declines in the number of new HIV diagnoses between 2015 and 2017 were observed in all affected groups, with particularly large falls in the numbers of gay and bisexual men in London being diagnosed (44%, from 1,415 in 2015 to 798 in 2017) (Nash *et al.*, 2018). The UK reports having met international targets for HIV treatment scale-up as part of a UNAIDS-led programme to end the global epidemic: that 90% of people living with HIV know their status; 90% of people diagnosed with HIV receive sustained antiretroviral therapy and that 90% of people receiving therapy will have an undetectable viral load (also known as the 90:90:90 targets). In 2017, 92% of people living with HIV in the UK were diagnosed, 98% of people diagnosed were receiving treatment and 97% of those had an undetectable viral load. Among people who were not diagnosed 'late' (defined as having a CD4 count ≤ 350 cells/mm³ at the point of diagnosis), 75% started treatment within 91 days, reflecting national recommendations on treatment initiation irrespective of CD4 count. These guidelines also recommend that the evidence that treatment reduces onward transmission be discussed with all people living with HIV (Williams *et al.*, 2012; Mayer and Beyrer, 2015).

Thus, the UK epidemic presents a situation which to a large extent has achieved many of the targets set in the global AIDS response. As well as the 90:90:90 targets being met, cities across the UK have signed up as Fast Track Cities in a Global Partner initiative with the aim of not only achieving the 90:90:90 targets but also eliminating HIV stigma (<http://www.fast-trackcities.org/about>). In 2019, the Fast Track Cities who had achieved the 90:90:90 targets committed to

continuing prevention and treatment programmes with the aim of getting to zero new HIV infections and zero AIDS-related deaths by 2030 as part of the 'Paris Declaration 2.0' (<https://www.iapac.org/files/2018/08/Paris-Declaration-2.0-07-24-2018.pdf>). This commitment to eliminate HIV transmission by 2030 was reiterated by the Conservative Party Secretary of State for Health & Social Care, Matt Hancock MP, during a speech at a major global HIV/AIDS summit in London in January 2019.

The use of ART as a tool to prevent HIV transmission has been taken a step further with pre-exposure prophylaxis (also known as PrEP), and has been shown to be effective, when taken by HIV negative individuals, in preventing HIV acquisition (Sullivan et al., 2012; McCormack et al., 2015; Molina et al., 2015). PrEP is available through the NHS in Scotland, Wales and Northern Ireland. The funding of PrEP by the NHS in England, however, has been controversial and the subject of press coverage and High Court litigation. In response to a ruling that provision of PrEP fell within its remit, in 2017 NHS England announced a three-year trial of the PrEP implementation. Subsequently, the routine commissioning of PrEP in England from April 2020 was announced in October 2019, but in response to a lack of detail on how the roll-out will operate, local councils called on the government for more information (Laycock, 2020; Local Government Association, 2020). In response to delays and a lack of routine commissioning of the treatment in England, community activists have been promoting PrEP through private prescription or imported generic drugs. Although reports at the time credited the recent decline in new infections to an increase in the number of HIV negative gay and bisexual men accessing PrEP (Cairns, 2017), Public Health England credits combination HIV prevention, including the initiation of treatment after diagnosis, with the dramatic fall in new diagnoses after several years of steady increases (O'Halloran et al., 2019). With TasP and PrEP at the heart of these approaches to tackling the epidemic, it is important to understand the lived experience of those for whom it is personally

relevant in order to ensure that political and public health responses align with the personal and intimate lives of those they affect in order to enhance their effectiveness. In the era of TasP, ensuring that people living with HIV are able to access treatment serves a doubly important function, improving the health of individuals and potentially tackling the epidemic. Yet while people living with HIV are reconfigured again as the route through which prevention will operate, Young (2019) points out that engagement and consultation with this key population has been slow to emerge. The research that has been carried out with communities of people living with HIV speaks to ambivalence towards TasP as a public health strategy, concerns about starting and staying on long-term treatment and diverse knowledge and engagement with the science of HIV, influenced by an intersection of biography, geography, race and sexuality (Persson, 2013a, 2016; Carter *et al.*, 2015; Grace *et al.*, 2015; Newman *et al.*, 2015, 2016; Keogh, 2016; Young, Flowers and McDaid, 2016). This research seeks to respond to these calls by investigating experiences of TasP as they are lived in the context of gay and bisexual men in serodiscordant relationships.

Social and biomedical responses to HIV risk over time

The development of antiretroviral treatment transformed the lives of people living with HIV and its continued refinement has led to further change through different eras of treatment. These differences extend beyond the immediate experiences of treatment and medical care itself and include how people diagnosed at different points in the epidemic relate to HIV and its social role (Rai *et al.*, 2018). In order to lay the foundations for my later analysis which considers how participant' experiences of HIV and of serodiscordancy have been transformed, I will first examine the ways in which different conceptions of the virus have influenced gay and bisexual men's lived experience.

In his review focusing specifically on gay men and HIV/AIDS risk management, Flowers (2001) proposes three distinct periods: confused; somatic; technological. The first, the 'confused', relates to a time when the science of AIDS and its cultural impact were poorly understood. The 'somatic' period relates to the period in which discoveries linking AIDS with bodies became understood, including the discovery of HIV itself. Finally, the 'technological period', is a period in which social and medical technologies began to play a significant role in risk management. Flowers' argument is that approaching an analysis of the history of HIV/AIDS in this way brings to light the multiple constructions of HIV/AIDS that have been produced through these time periods and how different frameworks to talk and think about the epidemic foreground different understandings and experiences. Tracing narratives of risk management on this timescale permits an analysis of the distribution of responsibility, and indeed blame, for managing (or failing to manage) HIV/AIDS risks. Race (2018) observes that the contribution of the social and the cultural to the transformation of the conditions of everyday life are often overlooked, perhaps because of their messiness and complexity. Arguably, the same can be said of progressive biomedicalised discourses of the 'transformation of HIV,' which can obscure the sometimes chaotic influence of grassroots responses that question neat histories of the development and deployment of HAART (France, 2016; Keogh and Dodds, 2020).

Despite the issues with providing simplified accounts of the social history of HIV noted above, in the interest of providing context and background for later data I have used a periodized approach to summarise key biomedical and social transformations of relevance to this thesis. The following account does not fully attend to the messiness and complexity of the processes of transformation, not to imply that these changes occurred neatly, but to avoid becoming mired in detail. Defining distinct periods in the history of HIV/AIDS risk management in this way can also make salient contrasts over time and provides a lens through

which to interrogate the origins and development of responses to HIV/AIDS. Flowers (2001) highlights that although these periods can be broadly distinguished in terms of their characteristics, they are not independent and each subsequent period builds on and is predicated on its predecessor. In the following section, I will make use of Flowers' 'periods' to structure the review of historical approaches to HIV prevention, followed by an in-depth account of the development of TasP and the associated emergence of the U=U campaign.

'Confused' and 'somatic' periods of HIV risk

When the first cases of deaths from pneumocystis pneumonia were reported, in 1981 in the USA and 1982 in the UK (Gottlieb *et al.*, 1981), the lack of information about the aetiology of these cases or the emergence of other opportunistic infections led to a primarily epidemiological response. The risk of disease was associated with a particular demographic: gay men. This led to an early naming of GRID (gay-related immune deficiency) (Altman, 1995) and through this association, lifestyle factors were implicated in the development of the condition. Through this focus on a particular 'at risk' group, processes of othering allowed the containment of the potential health scare among the general public. As a community, gay men were positioned not only as at risk, but also *posing a risk* (Flowers, 2001). The search for the cause of the condition with epidemiological tools led to a focus on gay male behaviour. Early theories focused on promiscuity as an aetiological factor, suggesting that symptoms related to the immune system becoming overloaded in response to repeated sexually transmitted infections (France, 2016). Previously unresearched aspects of gay and bisexual men's sexuality began to be examined by science and social science through the lens of illness (Phellas and Coxon, 2012). Through these processes, gay and bisexual men were collectively 'othered' and in the absence of a coherent public health responses, gay and bisexual men and lesbians became organised through the development of community organisations such

as ACT UP in the USA (France, 2016) the Terrence Higgins Trust, Gay Men Fighting AIDS and many others in the UK (Flowers, 2001). In this climate, AIDS was constructed as a community issue, which demanded a community response, such as the development of norms of safer sex. Participants who were sexually active in 1980s and early 1990s experienced HIV/AIDS before effective treatment through its impact on lovers, friends and acquaintances as well as through rumours and press coverage. Before the virus was identified and antibody testing became available, the physical manifestations of AIDS were the only way to know who 'had it.' Although there were relationships between those with and without AIDS diagnoses, in the absence of HIV antibody testing, the concept of a serodiscordant relationship as currently understood could not exist.

The isolation and identification of the pathogen associated with immune disfunction as well as development of understandings of the biological mechanisms of infection led to the emergence of the biomedical construction of this phenomenon as *Acquired Immune Deficiency Syndrome* and the causative agent *Human Immunodeficiency Virus*. This and the subsequent capacity to test for the presence of the virus began a process where HIV was located not only in particular communities but also and more specifically in *particular bodies* within these communities. Moreover, particular acts came to be associated with increased potential for transmission. Old conceptions of risk management that were predicated on reducing promiscuity in general became focused on particular sexual practices, namely the use of condoms for penetrative intercourse (Flowers 2001). In addition to this individualised conception of risk, the availability of HIV antibody tests transformed gay and bisexual men's identities, adding serostatus (as well as those who were untested) as a potential identity (Davis and Flowers, 2011; Young, Flowers and McDaid, 2016). Although these 'new' social identities were anchored those that had already formed in relation to the epidemic, the availability of markers of HIV infection afforded new ways to distinguish individuals based on their antibody status. Initially,

concerned about the potential for this divide the community – as well as the lack of any effective treatment – led to a resistance towards testing (Dawson *et al.*, 1991). For those who did take antibody tests, these could be sometimes seen as a symbol of engagement with HIV and ‘doing something’ (Willis, 1992) or, for those at lower perceived risk of HIV, a gesture of responsibility when starting a new relationship and of ‘purity’ (Lupton, McCarthy and Chapman, 1995). Even for those who had not tested, assumptions about serostatus could be made based on an individual’s sexual history. These new serostatus identities came with different obligations relating to risk management (Flowers, 2001). At this time, grassroots prevention efforts gave way to professionalised health-based approaches (King, Rooney and Scott, 1992). This approach to safer sex promotion focused less on community action and increasingly focused on HIV negative and untested gay and bisexual men, neglecting those who had been diagnosed (Keogh, 1996). The existence of a new category of asymptomatic HIV infected person transformed ideas of traditional sick roles and emphasised the importance of pursuing a ‘healthy’ lifestyle. It also opened up new social risks, such as rejection by partners and family (Green and Sobo, 2000). The focus on individualised risk management and knowing your status neglected the role of dyads and sowed the seeds for ‘semiotic snares’ (Davis, 2002) in which dyadic factors such as trust, undermined messages which focused on the risk of ‘unknown’ partners. The lack of any focus on ‘life after a diagnosis’ within public health messages about HIV/AIDS made the possibility of a relationship, let alone a serodiscordant relationship, unimaginable within the scope of political and public health regimes. Furthermore, the focus of these campaigns on the HIV negative or the untested began the process of establishing an HIV negative status as normative. By rhetorically dividing positive and negative gay and bisexual men through this focus, these early public health discourses around HIV set the scene for the ‘sero-divide’ (Persson, Ellard and Newman, 2016) that inflects accounts of serodiscordancy as inherently troubled.

For participants in this study who were children in the 1980s, their first experiences of HIV were dominated by arresting images from government-funded public awareness campaigns in the UK and Australia, which embedded their message about HIV transmission and the potentially deadly nature of HIV/AIDS in catastrophic terms. The abstract and shocking nature of adverts left many with a lasting impression of a featureless and deadly terror. Although how exactly HIV posed such a threat was unclear to younger participants, for some even gay sexuality itself was something that was potentially life-threatening. Although hailed at the time for their salience and impact on behaviour, the use of fear in public health campaigns has since been criticised as ineffective (Ruiter *et al.*, 2014) and exacerbating stigma and discrimination (Guttman and Salmon, 2004). For example, Adam (2005) highlights how a reliance on a neoliberal conception of people as rational actors serves to attribute blame to those who become HIV positive, by attributing them agency to have made 'bad decisions'.

'Technological' period of HIV risk

The political and biomedical response to HIV/AIDS was slow and grassroots organisations led initial care provision for people affected by AIDS, bringing together community members, social workers and community physicians to address the social and economic inequalities faced by people living with the condition and to challenge the lack of governmental engagement (Gould, 2009). These community groups were also active in seeking biomedical means to address HIV/AIDS, resulting in strategies for managing opportunistic infections being developed by community physicians (France, 2016). Protest and lobby orchestrated by these groups transformed the way in which pharmaceuticals were developed and approved (Clarke *et al.*, 2003; France, 2016). When the first antiretroviral treatments (ART) became available several years after the start of the epidemic they only delayed, not prevented, the onset of AIDS (Phellas and Coxon, 2012; AIDS.gov, 2016). Data presented at the Vancouver AIDS

conference in 1996 showed that the combination of a new class of drugs with existing treatments led to a rapid reduction in levels of the virus in those taking them, preventing progression to AIDS (Gulick et al., 1997; Hammer et al., 1997). This approach, which became known as highly active antiretroviral treatment (HAART), led to rates of death from AIDS declining in the countries where they became commercially available (Palella Jr et al., 1998; Harker, 2010). As noted earlier in this chapter, the provision of treatment was not made uniformly across the world and many low- and middle-income countries with significant epidemics could not immediately access patented and expensive treatments. Although these new therapies transformed the lives of people living with HIV, a contemporary report of their impact noted that initial optimism about their efficacy was tempered with caution based on previous experiences with unsuccessful treatments and the experience of side effects. In addition, the complexity and challenges of living with HIV meant that treatment became a small detail in a larger picture of meeting basic daily needs (Anderson and Weatherburn, 1998).

Although HAART was effective at preventing the development of AIDS and death, the combination treatment consisted of several tablets taken at different times of day and was associated with significant side effects. Further treatments associated with fewer side effects have become available and have been combined into single tablets, making the management of the disease as simple (for some) as taking one pill once a day. Living with the virus in the era of HAART has been likened to a long-term condition and the focus of medical management has shifted towards comorbidities associated with chronic HIV infection and the needs of an ageing population (European AIDS Clinical Society, 2016). The availability of effective treatment marked another biomedical transformation of HIV. A shift in emphasis from *suffering from* to *living with* complicated notions of sickness associated with being HIV positive (Flowers 2001). The success of treatment in extending life allowed some to readopt social roles and opened up

the possibility of embarking on longer-term life projects.

As with the development of treatments to HIV/AIDS, the initial response to the prevention of HIV transmission was led by community activists who advocated the use of condoms as part of a strategy that became known as 'safer sex' (France, 2016). As this approach was adopted by public health, condoms became the central pillar of HIV prevention, alongside calls for abstinence, other behavioural modifications and other strategies such as male circumcision. In the UK, the Conservative government embarked on a public information campaign of unprecedented scale and impact, with leaflets with safer sex advice distributed to every household and a series of high-profile television adverts, which featured images of cataclysmic icebergs and tombstones and focused on the central message of 'don't die of ignorance' (Fowler, 2014). Although the campaign was successful in raising awareness of HIV/AIDS and is credited by some as playing a role in the prevention of a higher rate of infections, the negative 'fear appeal' message of the campaign, coupled with the lack of subsequent campaigns has been criticised (Burgess, 2017) as leading to greater stigma of people living with HIV, the implication being that those living with the virus had been 'ignorant' of its dangers and cementing the virus as a deadly infection in the public consciousness. As I will discuss later, some of the stigma faced by participants in this study can be traced back to conceptions of HIV that have their roots in this era.

The mainstay of public health HIV prevention campaigns was an exhortation for gay and bisexual men to 'use a condom every time' and to consider themselves, and their partners, as potentially HIV positive. Although there were increases in rates of condom use, which was associated with historical lows of cases of STIs, data suggested that a proportion of men were not doing so (Dawson *et al.*, 1991; Hope and Macarthur, 1998; Hickson *et al.*, 1999, 2001). Gay and bisexual men worked with testing technologies and critically engaged with safer sex messaging: if both partners tested HIV negative (with allowance for the 'window

period' in which a recent seroconversion might not be detected) and they agreed a monogamous sexual relationship, then condoms could be dispensed with. While these practices were sometimes classified alongside condomless sex with unknown partners in surveys of sexual practices, this 'negotiated safety' was recognised and understood as a community response to new understandings of risk and biomedicalised identities (Flowers, 2001; Holt, 2014; Race, 2018). Certainly, reframing these behaviours in these terms acknowledges the agency of individuals and accounts for the emotional lived experience of living with and navigating evolving ideas of HIV risk. A transactional-rational view of decision-making also neglects aspects of the lived experience of negotiating relationships. In addition, critics of the approach and the construction of 'rational' sexual actors, have pointed out how in practice, emotional dimensions can lead to individuals disregarding or acting contrary to messages from public health campaigns (Adam, 2005, 2006; Davis, 2008; Robinson, 2018). Social scientists have drawn attention to the important role that love plays in supporting and sustaining serodiscordant relationships, which accounts that focus primarily on risk reduction fail to take into account (Flowers *et al.*, 1997; Rhodes and Cusick, 2000; Davis and Flowers, 2011). In addition to being integral to their ongoing practice, the emotional encounters with partners of different status speak to the potential importance of affect in the initiation of serodiscordant relationships (see Chapter 7, *The emotion work of disclosure*).

These experiences of HIV – both lived experience of the virus itself and experiences of it mediated through public health campaigns – set the background for subsequent encounters with HIV and with serodiscordancy. They show how the concept of a serodiscordant relationship emerged as the potential for difference solidified around new identities created by HIV serostatus and divided populations previously conceived as being at uniform risk. By introducing a distinction between individuals based on their serostatus, which acquired different social roles and expectations relating to HIV risk, biomedical

testing technologies transformed expectations of intimacy relating to HIV, creating the possibility of knowable serodiscordancy, but also introducing the beginnings of what has been termed 'the serodivide' (Persson, Ellard and Newman, 2016). These experiences also provide insight into how these processes of biomedicalisation were not deterministic but occurred unevenly through the actions of individuals negotiating the emerging biomedical developments in the unfolding social context. It also shows how multiple biomedical discourses can co-exist and even clash at key moments, such as diagnosis, as new or transformed images of HIV move unevenly through different social milieu. However, these accounts largely neglect how the biomedical, the social and the affective are messily intertwined in lived experience, highlighting the need for an account which brings into focus the intimate and the everyday.

Biomedical HIV prevention: Treatment as prevention and U=U

This section traces the development of TasP from an epidemiological concept to its 'proof of concept' in clinical studies and its social application through the discourse of U=U. I will argue that the scientific and biomedical discourses that present TasP as a 'breakthrough' projected to end the epidemic are a continuation of an optimistic trajectory that has underpinned successive eras of treatment. In addition, I will examine the way in which, even as an ostensibly community focused discourse, U=U operates on a similar trajectory which tends to overlook the everyday contexts and individuals through which this biomedical prevention technology operates.

Falling mortality from HIV/AIDS was coupled with increases in new cases of HIV and in this context, new epidemiological approaches to prevention were developed. These focused on the idea that the increase in new cases of HIV were driven by undiagnosed cases of HIV, as well as the perceived failure of behavioural measures. Within this population-level epidemiological approach,

concepts of 'community viral load' and 'test and treat' or 'find and treat' emphasised the importance of reducing the number of undiagnosed cases across affected populations and supplemented behavioural interventions with biomedical surveillance. The concept of using HAART as a tool to tackle the epidemic of HIV/AIDS was proposed by Montaner and colleagues in a paper in the *Lancet* in 2006 (Montaner *et al.*, 2006). In arguing for a role for expanded treatment in order to reduce the global incidence of HIV infection, the paper points to the 'failure' of other approaches to prevention to tackle the epidemic, creating a space for new approaches. It argued that the association between HAART and a reduction in transmission has already been established through the success of the prevention of vertical transmission and cites several studies which noted reduced rates of HIV transmission in serodiscordant couples when the positive partner was taking HAART. The paper also draws attention to mathematical modelling which suggested that any potential benefits of treatment could be undermined by an increase in HIV risk behaviour. I will focus further on studies of serodiscordant relationships and particularly their conceptualisation as sites of risk in Chapter 3.

The concept of TasP gained further prominence and was cemented as an epidemiological concept by the publication of a mathematical model which suggested that a combination of universal HIV testing followed by immediate treatment initiation could reduce the number of onward transmissions from each new infection to an extent that HIV would be 'eliminated' within 10 years of initiating the policy (Granich *et al.*, 2009). Although these conceptual and mathematical models drew on existing studies to advance their proposed approach to TasP, the first prospective study of the principle was HPTN-052 a clinical trial carried out in heterosexual serodiscordant partnerships comparing the impact of immediate with delayed initiation of HAART on rates of HIV transmission (Cohen *et al.*, 2011). The early results of the study suggested that immediate treatment with HAART led to a 96% reduction in the rates of

transmission from the positive to the negative partner, a rate that was higher than initially anticipated, resulting in the data and safety monitoring board overseeing the trial recommending the trial be halted early and all participants offered treatment. Following the study being presented at the International AIDS Society's Conference on HIV Pathogenesis and Treatment in July 2011 and published in the New England Journal of Medicine later that year, TasP was celebrated as Science magazine's scientific breakthrough of the year, with HPTN-052 highlighted as a 'game changer' (Cohen *et al.*, 2011). The optimism that frames these findings as potentially revolutionary echoes similar assertions made at the 1996 Vancouver meeting in which the data supporting the efficacy of HAART were reported and similar communications relating to vaccinations and strategies of cure (Kingori, 2016). These cycles of 'hope' and 'disappointment', highlight a tension between scientific optimism and the daily lived experience of HIV, in which such 'breakthroughs' are experienced in the context of ongoing challenges (Anderson and Weatherburn, 1998; Kingori, 2016).

Despite the widespread celebration of the results of HPTN-052, the focus of the study on stable heterosexual relationships who were counselled to use condoms as part of the study protocol, led some to question whether the benefits seen in the study would be replicated in more casual relationships or in other populations, such as men in same-sex relationships. Although some organisations extrapolated the results and suggested they applied to all sexual transmission, others were more conservative and Cohen and colleagues suggested that a definitive answer would require further randomised studies to answer, which would be unlikely to receive ethical approval (Padian *et al.*, 2011). In answer to these questions, the PARTNER study (Partners of People on ART—A New Evaluation of the Risks) was initiated (Rodger *et al.*, 2016). PARTNER was an observational study of heterosexual and same-sex serodiscordant relationships in which partners reported at least one incidence of condomless

sex in the past month and the HIV positive partner with a known viral load <200 copies/ml at the start of the study. As an observational study without the strict conditions of a randomised placebo controlled clinical trial, PARTNER was able to examine the impact of HAART on HIV transmission in relationships where the partners had already reported sex without condoms. The initial results were presented in 2014 at the Conference on Retroviruses and Opportunistic Infections (CROI) and showed no transmissions of HIV from a positive to a negative partner. Although the study enrolled participants in both heterosexual and same-sex relationships, the initial study did not provide enough data to generate results with the same degree of mathematical certainty for both kinds of relationship. As a result, the PARTNER2 study, which enrolled exclusively gay and bisexual men in serodiscordant relationships was initiated in order to provide further follow up on the impact on HAART on rates of transmission through condomless anal sex (Rodger *et al.*, 2019). Coming some time after the HPTN-052 and PARTNER results were announced, the results of PARTNER2 were contextualised somewhat differently, as I will consider in the following section.

In their initial outlines of the concept of TasP both Montaner and Granich point to limitations of the strategy, including not only increased cost and use of resources, but also concerns about higher rates of treatment resistance and concerns about the potential for enforced testing. Critics also pointed to ethical concerns associated with treating a population for the benefit of others, exposing people to years more treatment and side effects than would be necessitated for their own health (Lloyd, 2016). This was reflected in the 2012 British HIV Association (BHIVA) treatment guidelines, which although recognising the potential benefit in terms of reduction of sexual transmission and recommending individual discussion about this benefit between physicians and patients, maintained a threshold of 350 CD4 cells/mm³ due to concerns that there was insufficient evidence of benefit of beginning treatment earlier

(Williams *et al.*, 2012). In 2015 the results of the START study demonstrated that immediate treatment with HAART led to superior health outcomes for people living with HIV compared with delaying treatment until a threshold of 350 CD4 cells/mm³ had been reached (Lundgren *et al.*, 2015). With the START study results, TasP became an approach that was not only theoretically plausible and supported by clinical trial evidence, but one of the final barriers to its wider implementation was removed. In 2015, the World Health Organisation issued guidelines recommending that all people living with HIV be offered treatment, both for their own health benefit and for its impact on onward transmission. Later that year BHIVA guidelines were also updated to recommend that treatment be initiated regardless of CD4 counts (Churchill *et al.*, 2015). These population-level approaches were formally adopted internationally in the UNAIDS 90-90-90 targets. As it became incorporated into the vocabulary of the 'AIDS Industry' (Patton, 1989) TasP became a universal concept that obscured its origins as a programme of studies directed by a community of researchers with careers and personal objectives (Nguyen, 2015).

Through its incorporation into medical guidelines, TasP the epidemiological concept also promised to transform intimate lives. One of the earliest formulations of TasP on the individual scale was proposed in 2008 by a group of physicians from the Swiss HIV Association, who suggested that an individual living with HIV who had levels of virus below that which could be detected with standard tests for more than 6 months and had no active sexually transmitted infections could be considered uninfected through sexual routes (Vernazza *et al.*, 2008). Initially controversial, the 'Swiss statement' was based on the experiences of physicians and the patients they treated, alongside emerging scientific evidence and was intended in part as a response to the criminalisation of HIV transmission (Vernazza and Bernard, 2016). The results of HPTN-052 and PARTNER studies (Cohen *et al.*, 2011; Rodger *et al.*, 2016) showed no linked infections in serodiscordant couples where the positive partner had a

documented undetectable viral load. This provided further evidence that supported the 'Swiss statement' and showed that as well as the epidemiological benefits, TasP has benefits for people living with the virus and their partners. In 2016 the Prevention Access Campaign, a community-led initiative that was formed to improve awareness and access to HIV prevention in the USA developed a consensus statement under the banner of 'Undetectable = Untransmittable,' abbreviated to U=U. The authors of the statement included physicians involved in the early studies that developed the concept of TasP and the lead author of the 'Swiss Statement' (Prevention Access Campaign, 2017). The initial U=U consensus statement, below, built on the initial position established in 2008, but retained a mention of the length of time that it could take for an undetectable viral load to be attained:

People living with HIV on ART with an undetectable viral load in their blood have a negligible risk of sexual transmission of HIV. Depending on the drugs employed it may take as long as six months for the viral load to become undetectable. Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits.

Prevention Access Campaign

(<https://www.preventionaccess.org/consensus>)

This statement has become the foundation for an advocacy and information campaign, with more than 950 'community partners' from more than 100 countries endorsing the U=U message. In campaign materials, there has been a simplification of the longer statement focused on the lack of risk of transmission, for example: 'A person living with HIV who has an undetectable viral load does not transmit the virus to their partners.' (Prevention Access Campaign, 2017). In the UK, the Terrence Higgins Trust further simplified the U=U message, using it as the basis for a series of public information campaigns under the banner of

'Can't Pass It On' (see Figure 1). As well as a campaign to raise awareness of TasP under the banner of U=U, the campaign focuses on the individual benefits of uninfectedness, both for individuals living with HIV and their partners, through allaying fears of transmission, but also aiming to tackle wider stigma associated with HIV by showing that through undetectability, it cannot be transmitted. The Prevention Access Campaign has supplemented 'Undetectable = Untransmittable' with 'Science not Stigma' and 'Facts not Fear', establishing U=U as not only a campaign to raise awareness among people living with HIV and their partners in order to support individual relationships, but through a wider reach, change attitudes to people living with HIV within society. The explicit focus on fear and stigma positions TasP as an emancipatory project as well as a public health, epidemiological one. Yet, despite this focus on the social, TasP and U=U are anchored in the scientific method of discovery. They were created through a process that purposely excludes the social in order to show the efficacy of the intervention under test (Nguyen, 2015). This 'blind spot' becomes apparent when they are applied to the social and overlook the complexity of phenomena such as stigma, reifying it as a symptom to be alleviated, rather than a social process bound up with power relations (Link and Phelan, 2001). As a future-oriented biomedical transformation (Clarke *et al.*, 2003) TasP focused the international medical community on an anticipatory future, the 'end of AIDS' (Lloyd, 2016). TasP promised to transform the future of the epidemic independent of the people living with HIV through whose bodies and relationships those transformations would be achieved. In addition, by foregrounding the 'science' U=U further obscures the experiences and concerns of the very people who will make this biomedical technology operate in the everyday (Keogh, 2016; Young, Flowers and McDaid, 2016).

Figure 1: UK TasP advertising campaign – Can't Pass It On



Since the launch of U=U, two further studies of serodiscordant couples have presented results and have been framed as further confirmation of the principle of TasP. The Opposites Attract study included 358 men with HIV in same-sex serodiscordant relationships from three different countries including Australia, Thailand and Brazil (Bavinton *et al.*, 2018). As with the PARTNER and PARTNER2 studies, participants engaging in condomless sex were included and approximately 17 000 acts of anal sex without a condom were studied. Following a similar approach to the PARTNER study, the results of Opposites Attract were framed in terms of further confirmation of the applicability of TasP to same-sex male couples. An editorial in *The Lancet* reporting the results of the study in 2018 noted, *'Three new cases of HIV infection were observed but, as expected, none of these infections were linked [to the primary partner]...'* (Cohen, 2018). In denoting the seroconversions of HIV negative study participants as 'successes' of TasP because they originated outside the serodiscordant partnership, the editorial obscures the social and intimate meanings of the diagnosis for the participants to whom it occurred. This further highlights a tension between biomedical and individual notions of 'successes' and 'failures' in which an

intervention that can have said to have been successfully proven nevertheless involves events that on an individual level could be understood as having failed (Kingori and Sariola, 2015). The editorial also decontextualized U=U as a message that not only benefits people living with HIV and their partners, but also contributes to tackling the epidemic and achieving the UNAIDS 90-90-90 targets. It presents U=U as bridging the personal and the epidemiological: through its focus on stigma and lessening the burden of living with HIV it has the potential to encourage greater engagement with HIV treatment itself, further reducing transmissions as more people engage with HIV testing and treatment. This optimistic tracing of the benefits of U=U once again obscures the complexity of the lived experience of people living with HIV and the choices they make around starting treatment. In portraying the decision to start treatment as a rational risk-benefit calculation, the editorial relies on sociologically simplified conceptions of risk (see Chapter 3) and ignores important contextual influences on treatment initiation, not least political and economic barriers to treatment access.

Following the widespread ratification of the U=U statement by a number of community and professional organisations around the world, the focus of communications for Prevention Access Campaign has been not only raising awareness among individuals affected by HIV and society more broadly but also to encourage all healthcare professionals involved in the management of people living with HIV to endorse and communicate U=U (Calabrese and Mayer, 2019). Despite early controversy over how 'safe' condomless sex was for HIV transmission (Daar and Corado, 2016), the accumulation of evidence was presented as overwhelmingly supporting the concept of TasP. At a plenary session at the International AIDS Conference in Amsterdam in 2018, following a presentation of the PARTNER2 study results, which also demonstrated no linked transmissions between serodiscordant male partners, Alison Rodger directly challenged healthcare professionals who were doubtful of TasP: *'It is very, very*

clear that the risk is zero. If you are on suppressive ART you are sexually non-infectious. The time for excuses is over.' (Keogh and Dodds, 2020) In this formulation of U=U, not only has the terminology of 'negligible' become a more categorical 'zero', but in its formulation it has gained even greater rhetorical force: not only is it clear, it is undeniable and incontrovertible. Although other U=U proponents, such as Dr Anthony Fauci, Director of the USA National Institute of Allergy and Infectious Diseases (NIAD), have recognised in interviews about TasP that 'zero' is a convenient shorthand rather than a scientific certainty, he also presents the idea that for someone HIV positive and undetectable, *'from a practical standpoint, the risk is zero, so don't worry about it.'* (Robbins, 2018). In offering this reassurance, Fauci leaves the detail of *how* to translate U=U into their everyday lives to people living with HIV and their partners. I will explore how participants perceived a gap between knowing that TasP meant there is no risk and their confidence that their particular practices were free from risk (see Chapter 6, *U=Uncertainty*).

Keogh and Dodds (2020) suggest that these articulations of U=U can be understood through the lens of Novas's political economies of hope: *'patient activism shapes and is shaped by biomedical research agendas and realises specific forms of bio-political capital through enactments in spaces beyond the clinic: at conferences and meetings, in news and social media.'* With greater evidence supporting TasP and anecdotal evidence that understanding U=U can transform the perceptions of people living with HIV about themselves and their relationships, the U=U campaign has taken an epidemiological concept and made it an issue of personal and professional ethics: for individuals it is not worth concern, for healthcare professionals not to believe and inform others about it is inexcusable. The move towards broader acceptance of TasP is also seen within communities of HIV negative gay and bisexual men, in whom awareness of TasP has been shown to be increasing over time, along with an accompanying transformation in attitudes towards people living with HIV (Holt et al., 2016; Card

et al., 2018; Siegel and Meunier, 2019). By charting and closely associating awareness and 'acceptance' of TasP, these studies further the model put forward by the U=U campaign which equates awareness of 'the science' with an expectation of a social transformation, either in terms of behaviour or in reduction of stigma. Presupposing a simple 'conversion' to understanding and accepting U=U, leaves no space for ambivalent or complex responses to TasP and also suggests an optimistic future in which everyone is aware of and accepts TasP. I will return to the way in which participants negotiated TasP in the context of their relationships in Chapter 6.

A criticism of the U=U campaign is that it ignores the challenges of diagnosis and access to treatment in parts of the world that have not prioritised HIV within health budgets or where presenting for testing or being identified as HIV positive is potentially dangerous due to high levels of stigma and violence (Bereczky, 2019). Even in contexts where violence is not a primary concern, people living with HIV do not always feel able to engage with others about TasP, compounding stigma and isolation (Young *et al.*, 2019). These criticisms echo Nguyens' critique (2010) that 'remedicalising' HIV prevention can undermine approaches that take in broader social and political influences. Adam (2011) also highlights how biomedical approaches are necessarily social interventions and argues against a narrow focus on biomedical prevention without taking in the social, political and economic structures which necessarily inform and support the biomedical. Whereas many of the HIV risk management approaches adopted in the 'technological period' (Flowers 2001) have had their origin in the practices and experiences of gay and bisexual men, by taking the biomedically based TasP as its root, the U=U campaign stands apart from strategies such as negotiated safety or strategic positioning. Although the practices that it supports, particularly condomless sex, have important meanings for men in same-sex relationships - being associated with feelings of love and trust, among others (Flowers *et al.*, 1997), the bedrock of the campaign rests on epidemiological

concepts and scientific evidence accumulated through clinical studies, rather than the lived experience and practices of gay and bisexual men. These critiques stem from the paradoxical way in which the scientific method that created them obscures the social and intimate domains in which they operate. This underlines the need for research that is situated within the frame of everyday experiences of intimacy in order to provide an account of how TasP and U=U are lived in practice.

Summary

In this chapter, I have outlined the epidemiological and policy context in the UK particularly the implementation of TasP, which underpins the lived experience of participants in this study. I have also provided an account of the interwoven nature of the lived experience of gay and bisexual men, their experiences of HIV and approaches to HIV prevention. In doing so, I have drawn attention to arguments that in many points throughout the history of HIV prevention, gay and bisexual men themselves have led innovation in risk reduction practices, which have later informed public health approaches. I have also traced the development of TasP in more detail and the emergence of U=U as a community led articulation of TasP with a primary focus on the benefit to individuals. I have argued that whereas previous innovations in risk management, such as negotiated safety, have their origins in individual and community practices, TasP and U=U stand apart as articulations of epidemiology, modelling and global prevention policy. I have critiqued the way in which the biomedical projects that produced TasP and U=U have overlooked the very contexts in which they operate. I will later examine the implications for participants as they seek to apply a population-level concept in their individual lived experience and their relationship practices.

3. Literature review and theoretical framework

'Theory, in any empirical discipline must be relevant in a double fashion to the data defined as pertinent to that discipline. It must be congruent with them, and it must be geared to further empirical enquiry'

Berger and Luckman (1991)

In their classic treatise on the social construction of reality, Berger and Luckman highlight a bind for sociology, which finds itself caught between the 'everyday' view of reality that it takes as its object of study and philosophical approaches which seek to examine the epistemological foundations that underpin reality. They argue that although sociology should be distinct from philosophical approaches, it cannot proceed without taking account of the nature of the everyday reality that it seeks to examine. It is therefore crucial to define a theoretical framework through which this reality can be understood. In this chapter, following Berger and Luckman's example, I will engage with both the empirical and the theoretical, examining the existing literature on serodiscordancy and how it has developed. In doing so, I will distinguish between different disciplinary approaches and engage with how these have constructed serodiscordancy through their enquiry. I will highlight a recent call by Persson and Hughes (2017) for a holistic examination of serodiscordancy that takes into account the range of lived experience away from managing transmission risk and from constructions of serodiscordancy that universalise experience. I will also discuss two distinct bodies of theory through which to interpret this existing literature on serodiscordancy, of biomedicalisation and a body of work on intimacy, and consider how these can be brought together to guide further enquiry into the experience of serodiscordancy.

Understanding serodiscordancy

Within the social sciences, HIV/AIDS highlighted a gap in understanding and raised key questions about the sexual behaviour of men who have sex with men, the prevalence of risk behaviours and the social contexts of HIV transmission. In order to support health promotion efforts to tackle the growth of the epidemic, programmes of research were initiated in the USA and Europe to define populations at risk of HIV and establish patterns of sexual behaviour within and between them (Phellas and Coxon, 2012). Often funded by medical and health departments, and in the face of political resistance to funding social research, these studies often took quantitative and explanatory approaches to the questions at hand. This growth of social scientific research in sexuality, in response to the HIV epidemic led to much of the work, *'examining sexuality from the perspective of Aids rather than Aids in the perspective of sexuality'* (Gagnon, 1988). In addition, at the time HIV/AIDS first emerged, conducting research into gay and bisexual men's sexuality was complicated by stereotypes, assumptions and divisive theories of 'homosexual behaviour' (Davies et al., 1993).

A literature on HIV/AIDS and HIV prevention has developed and, as with any large body of research completed by diverse and competing research groups, several traditions emerged each operating within their own national, institutional and paradigmatic conditions. This thesis focuses on the anglophone literature and context. From the USA, research focused on behavioural and epidemiological investigations investigated gay and bisexual men's sexual networks and sought patterns and opportunities for intervention in sexual risk behaviour (e.g. Ekstrand et al., 1999). In the UK a group of researchers sought to frame their research into safer sex within an understanding of the meanings and affects attached to sexual acts and sexual risk, conducting a large study of the sexual practices of gay and bisexual men across England and Wales from 1987 to 1991 (Davies et al., 1993; Green, Aggleton and Davies, 1995). An allied approach to HIV social science research was taken in Australia, which

deliberately proposed 'the object of study is sexual *practice* as opposed to sexual behaviour' (Kippax and Stephenson, 2005). Emphasizing meaning and practices draws attention to the socially embedded nature of sexuality and the historical and contextual contingency of its expression, over a focus on behaviour that moves towards objective measurement and correction (Race, 2018).

A comprehensive discussion of the differences between these approaches is beyond the scope of this thesis, but the following example illustrates how these competing enterprises constructed and examined their subjects differently. The practices approach espoused by Kippax and colleagues at the National Centre in HIV Social Research in Australia and Weatherburn and colleagues at Sigma Research in the UK allowed more nuanced understandings of strategies being employed by gay and bisexual men by including key contextual information that more epidemiological approaches were not sensitive to. For example, in many studies any condomless sex was classified in studies as a 'risk behaviour' and a failure of safer sex messaging, regardless of the context in which it occurred. Developing an understanding that some men were only engaging in condomless sex within a monogamous relationship highlighted gay and bisexual men as active agents deploying multiple strategies and, in doing so, brought to light approaches to prevention that had not been officially recognized. Establishing this approach as 'negotiated safety' and men's autonomy provided an opportunity to provide guidance on how to make this strategy safer (Kippax *et al.*, 1993, 1997; Keogh *et al.*, 1998; Bourne *et al.*, 2015), rather than considering it as 'negotiated danger' (Ekstrand *et al.*, 1999; Zablotska *et al.*, 2009). The tensions present within this body of research also inflects studies examining serodiscordant relationships, which I will turn to next.

Studying risk in serodiscordant relationships

As outlined in the previous chapter, the availability and efficacy of treatment had profound implications for the way in which HIV/AIDS was experienced. Few studies of serodiscordant relationships were published before 1996. Those that were focused on the tensions experienced by partners in mixed-status relationships, uncertainty and adapting to changing relationship roles if the HIV positive partner's disease progressed, and the adaptations they made to cope with these tensions (Padian, 1990; Klimes *et al.*, 1992; Remien and Carballo-Diequez, 1995). Following the improvements in outcomes resulting from HAART, concerns about survival were pushed to the background and prevention of transmission became a focus of research. A review and meta-analysis of socially orientated psychological and medical research in serodiscordant relationships published after 1996 found that most studies focused on sexual risk behaviours and risk management, with relationship quality and social support examined in a minority (Mendelsohn *et al.*, 2015). A body of research on serodiscordant couples in the counselling and psychotherapeutic literature speaks to the challenges faced by HIV positive people and their partners. Studies focussed on counselling techniques to support coping with stress relating to diagnosis or estrangement from family and friends (Beckerman, Letteney and Lober, 2000; Beckerman, 2002a, 2002b). In order to address these 'stressors' psychosocial support programmes have been created in partnership with men in serodiscordant relationships (Eaton *et al.*, 2018). The review also identified a number of surveys carried out examining patterns of sexual relationships, which reported intercourse both within and outside partnerships. These studies found that positive partners in serodiscordant relationships were more likely to take sexual risks (defined in these studies as unprotected anal intercourse [UAI]) with their regular negative partner than with negative casual partners (Crawford *et al.*, 2003; Hoff *et al.*, 2005, 2016; Poppen *et al.*, 2005; Ostrow *et al.*, 2008). In order to explain behaviour that ran contrary to public health advice, researchers turned

to cognitive models, suggesting that negative partners in serodiscordant relationships were more likely to have positive opinions of HIV treatment and reduced concern about becoming positive themselves (Crawford *et al.*, 2003; Ostrow *et al.*, 2008). Other studies found that men appeared to be taking on messages about HIV transmission risk, but rather than abstaining from UAI were modifying their behaviour in response to their partner's HIV status, with behaviours associated with the greatest risk of HIV transmission reported less often (Hoff *et al.*, 2005; Van de Ven *et al.*, 2005). Some research suggested that individuals who were engaging in UAI were psychologically different from those who practiced safer sex, with personalities disposed to 'sensation seeking' (Israel, Romeis and Spitz, 2005).

As evidence emerged of a reduced risk of transmission associated with an undetectable viral load, several studies examined whether men were incorporating their perceptions of viral load into decisions around condomless anal intercourse. Surveys in the USA, Europe and Australia measured the frequency of viral load discussion in relation to sex with regular and casual partners. They found that men in serodiscordant relationships reported discussion of viral load with their partners and in some casual encounters, but it was not universal. Where viral load was discussed, no clear pattern emerged between discussion and subsequent UAI, with some finding that discussion had no correlation with UAI and others finding that it did, but only in the context of serodiscordant partnerships (Stolte *et al.*, 2004; Van de Ven *et al.*, 2005; Guzman *et al.*, 2006; Prestage *et al.*, 2009; Horvath *et al.*, 2012). Other studies made the distinction between positive men's impression of their viral load with their actual viral load, pointing out that it was the former which appeared to influence their behaviour even when a proportion who considered themselves to be undetectable had a measurable viral load (Stolte *et al.*, 2004; Stephenson *et al.*, 2020).

Studies comparing serodiscordant partnerships with other relationships found differences in the behaviours reported by partners. Negative partners in serodiscordant relationships were more likely to report HIV testing after UAI with a casual partner than men in relationships where both reported being HIV negative (Chakravarty *et al.*, 2012). Studies of men in same-sex relationships in the USA found that negotiated agreements about sexual behaviour with casual partners were almost universal among participants (Hoff *et al.*, 2009; Hoff and Beougher, 2010). Survey data suggested serodiscordant couples were the most likely to have an open relationship with no restrictions on behaviour, while couples of the same status reported monogamous agreements most frequently (Hoff *et al.*, 2009). Qualitative data suggested that although HIV and sexual health were considerations in partners forming an agreement, their primary function was to affirm and strengthen the relationship (Hoff and Beougher, 2010).

These studies place HIV risk in a paradigm consistent with health promotion campaigns with the monolithic message to always use a condom for anal intercourse. By this rationale, any UAI is a potential risk for HIV transmission and many of these studies construct condomless sex as an alarming problem that needs an urgent solution through education and behaviour change programmes (Stolte *et al.*, 2004; Israel, Romeis and Spitz, 2005). Although some researchers have argued for a more nuanced understanding of risk in relation to condom use - taking into account relationship context (Crawford *et al.*, 2001), or more recently, that recognise the role that treatment can play in reducing sexual transmission of HIV (Jin *et al.*, 2015; Daar and Corado, 2016) – these studies still retain an explicit interventionist orientation: understanding behaviours and risk in order to modify them through education or behaviour change. This body of research operates within a techno-scientific paradigm for risk (Lupton, 1999). Here, risk is understood as mathematically defined but imperfectly understood by human subjects. Risks are therefore managed by increasing individual and

collective understanding of risk factors and providing individuals with tools to reduce risk as far as possible. Greco has argued that this paradigm brings forth discourses on the governance of health, in which independent individuals are subjected to regulatory efforts to encourage 'healthy' decisions.

'If the regulation of lifestyle, the modification of risky behaviour and the transformation of unhealthy attitudes prove impossible through sheer strength of will, this constitutes, at least in part a failure of the self to take care of itself – a form of irrationality, or simply a lack of skilfulness'

(Greco, 1993: 361, in Nettleton, 1997).

Thus, there is a need to equip those at risk or who lack skills to have the means to avoid 'unhealthy' choices in favour of 'healthy' behaviours. Nearly all the studies highlighted discuss shortcomings in current health promotion campaigns relative to their findings and make suggestions for how these should be updated to help guide better decisions or counteract mistaken beliefs. Keogh additionally highlights that these discourses rest on a neoliberal politics which emphasises individual responsibility for adopting behaviour in order to maximise productivity and minimize burden on the state (2008a). Further to this, Young highlights how the expectation of individuals to not only engage in appropriately healthy activities, but to 'strive to be healthy' through engagement with processes of diagnosis, treatment and monitoring (2019) (See *Biomedicalisation*, below). Couple dynamics can shape an individual's engagement with health, as couples conceive of their health as closely connected (Gamarel et al., 2016).

Relying on the rationalising, risk-averse framework that underpins much public health-informed research into sexual behaviour and HIV has led to a narrow understanding of risk and how it relates to lived experience (Obermeyer, 2005). Combining disciplinary approaches, as I intend to in this analysis, can therefore help to deepen understanding. In addition, the use of social cognition models to understand sexual gay and bisexual men's sexual practices can oversimplify

decisions that take place in the context of multiple social influences (Flowers, Duncan and Frankis, 2000; Flowers and Duncan, 2002). It is notable that the reasoned approach supposed by these models stands at variance to broader cultural understandings of sexual behaviour which often emphasise its emotional, instinctual and spontaneous nature. Construction of 'irrational' behaviour has been found to be widely used in health promotional literature about safer sex and HIV risk (Keogh, 2008a). The validity of models that suppose a linear relationship between cognitive factors, decision making and behaviours can also be legitimately questioned (Flowers and Duncan, 2002). These models fail to take into account broader social factors that do not relate to HIV risk reduction but can nevertheless inform behaviour, such as the desire to express a transgressive sexual identity in a heteronormative society (see Chapter 6, *Negotiating serodiscordant sexual practice*). Further, behaviours defined as 'safe' or 'risky' in public health discourse can easily slip to 'desirable' and 'undesirable' behaviours, perpetrated by 'good' and 'bad' individuals. This moral undercurrent is not unique to studies of HIV risk, however. Lupton argues that all discourses of public health and health promotion are inherently normative and rest on moral logic; the pursuit of health and avoidance of illness is constructed as the only 'proper' way to live (Lupton, 1995). Focusing on health behaviour in isolation also neglects other influences on behaviour, such as tensions between individualised conceptions of safer sex and broader conceptions of individuality, success and masculinity that operate in a social context dominated by neoliberal marketisation (Adam, 2016). Discourses of rationality, powerfulness capability and competitive individualism can provide ways for men to navigate their masculinity in work and relationships; indeed risk-taking itself can be seen as a masculine trait (Rhodes et al., 2011). These clash with sexual health discourses that centre on caution and risk aversion and result in behaviours that run counter to the normative moral logic (Lupton, 1995) that underpins public health approaches. Further complicating this picture, Keogh and colleagues (1999) describe additional 'risks' associated with condomless

sex, away from the risk of HIV and STI transmission. Gay and bisexual men who had participated in condomless sex were concerned about the social risk of being perceived as irresponsible and the risk to their sense of *themselves* as moral actors. The co-existence of these competing, contradictory and interacting social discourses, highlights the messiness inherent to studies of sex and intimacy, suggesting that 'deficit' models of sexual health behaviour miss important social contexts, which demands a more nuanced approach to examining and understanding sexual practices. I will discuss how notions of responsibility and irresponsibility underpinned participants' understanding of their sexual practices and how TasP facilitated their renegotiation of boundaries of (ir)responsibility in Chapter 6.

Understanding serodiscordancy in context

In contrast with the public health-orientated research examined thus far, a related social scientific literature embraces a more nuanced understanding of social context and its influence on behaviour. Rather than the techno-scientific view provided in health promotion, these studies take a phenomenological approach to risk, drawing out the way in which individuals ascribe meaning to their actions and how decision making is embedded in a wider social world (Lupton, 1999). These studies document how the risk of transmission and adherence to safer sex serves to disrupt partners' feelings of intimacy. Couples work to negotiate a balance between this threat to the continuation of the relationship with the risk of HIV transmission (Cusick and Rhodes, 2000; Rhodes and Cusick, 2000; Doyal and Anderson, 2005; Jarman, Walsh and De Lacey, 2005; Tairy *et al.*, 2018). In some cases this threat is managed by excluding HIV from relationship talk (Persson, 2008). In others, relationship integrity becomes more important and overturns safer sex as time goes by, resulting in a trajectory towards condomless sex (Cusick and Rhodes, 2000; Rhodes and Cusick, 2000). In these studies, HIV negative partners were seen as using condomless sex to

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demonstrate love and commitment and the 'health' of the relationship is balanced against the HIV negative partner's health. Rather than constructing this as a conflict between prioritisation of the relationship over HIV transmission, and alternative analysis rests on the way in which this relationship dynamic reflects wider societal attitudes towards HIV status (Davis and Flowers, 2011). HIV negative partners can symbolically contribute more to the relationship by their willingness to sacrifice their negative status; something their positive partner is unable to do. This highlights a further asymmetry: the positive partner is held ultimately responsible for transmission risk, even when the negative partner engages in condomless sex willingly. These phenomena rest in part on dominant HIV discourses which position HIV seronegativity as normative. Viewed in this way, the negative partner's status gains intrinsic value and the offer of condomless sex becomes a gift and an expression of love. This highlights how biomedical information about serostatus becomes intertwined with notions of love, social ties and reason (Davis and Flowers, 2011). Biomedical prevention technologies like TasP and PrEP not only alter the risk of HIV transmission, but can themselves function as facilitators of relationship dynamics. By inviting discussion about sexual practices, relationship forms and emotional needs, these interventions can function to support relationship intimacy (Malone et al., 2018). The central role of love and romance in sexual practices is further supported by a study of men in regular sexual partnerships, which found that those who reported being in a romantic or committed partnership reported more condomless sex, but also greater use of risk reduction strategies, such as relationship agreements (Bavinton et al., 2017). Thus a thorough exploration of the influence of TasP on serodiscordancy needs to take into account not only the meaning of sexual practices within a relationship but also how the biomedical interacts with relationship intimacy, as I will discuss later in this chapter (see *Engaging with Intimacy*).

Two consecutive studies have focused on the impact of TasP on both heterosexual and gay/bisexual serodiscordant relationships. They paint a changing picture of couples' attitudes towards the concept and their interpretation of its relevance to their relationship. The first study was conducted shortly after the publication of the 'Swiss Statement' (Vernazza *et al.*, 2008) as part of an ongoing study of HIV-positive heterosexuals and their HIV-negative partners (Persson, 2010). Data gathered before the Swiss Statement publication indicated that some couples were regularly engaging in unprotected intercourse and, as with the studies above, their behaviour appeared to be driven primarily by emotions and relationship dynamics than by calculations of transmission risk. In this heterosexual population, additional factors relating to gender dynamics, reproduction and a desire for 'normality' also influenced couples' condomless sex. Interviews conducted the year after the Swiss Statement publication found that all but one participants were unaware of TasP. While welcoming the statement as a generally positive step, which had the potential to ease HIV stigma in the general population, participants were sceptical of its applicability to their personal situation. Several discussed the need for more evidence of the efficacy of TasP before altering their sexual practices. Others had more fundamental objections to the idea that someone could carry the virus yet be uninfected. Persson (2013) suggests that powerful embodied conceptions of personal infectiousness contributed to participants' scepticism about TasP, coupled with a prioritization of personal context and experience over medical data. For example, a HIV positive participant who had experienced transmitting the virus to a former partner continued to perceive of herself as infectious despite an undetectable viral load and couples who had never used condoms before reprioritised safer sex to protect the negative partner's health after starting a family. The importance of biographical influences on serodiscordant relationships highlighted here points to the need for an analysis that takes into account individual lived experience.

A more recent study by the same research group included 7 heterosexual and 16 gay serodiscordant couples (Persson *et al.*, 2016). Researchers found a range of sexual practices, including no condom use, consistent condom use to total abstinence. Nine of the gay couples reported using condoms consistently, one had only non-penetrative sex, one used condoms some of the time and the remaining five couples practiced condomless sex. Couples who became serodiscordant after meeting reported using condoms more frequently than couples who were serodiscordant from the beginning of their relationship. In those couples that used them, condoms were frequently described as a barrier to full intimacy but were reluctantly accepted as a risk reduction tool. Treatment was perceived by HIV positive partners as a 'given' as it served to protect both their and their partner's health; having a negative partner was a strong motivator for remaining engaged with clinical care and having regular viral load checks. Specifically focusing on TasP, more participants were aware of it as a concept than in earlier studies and both HIV positive and HIV negative participants viewed it as an overwhelmingly positive development, despite some expressing concern that it could cause some people to feel pressured into starting treatment or stopping using condoms. Across participants, TasP was viewed as particularly important for serodiscordant couples as, by reducing risk, it has the potential to reduce anxiety about transmission, providing a sense of normalcy and optimism about the future. Reductions in anxiety have also been described by serodiscordant partners who use PrEP to manage transmission risk (Bosco *et al.*, 2019). Persson (2016) describes three prevailing themes regarding the role that participants felt TasP could play. The first, 'an extra layer or protection' was common among gay couples who used condoms consistently. Participants continued to frame condomless sex as 'unsafe' and focused on the risk reduction reported in trials in terms of the residual risk: they felt that even a small chance of transmission was too great and that condoms were still synonymous with 'safe sex'. A second theme 'welcome relief, reassurance or validation,' was common among couples (both heterosexual and gay) who were not consistently using

condoms, with TasP providing additional support for the choices they had already made in their relationship. Finally, a minority of couples who had struggled with continuing to use condoms viewed TasP as providing 'permission to commence condomless sex' and liberating their relationship from previous concerns relating to condom use and guilt. Participants from across these themes focused on 'undetectability' as a key factor in TasP and thus an important facilitator of serodiscordant relationships. Persson speculates that the shift towards acceptance of TasP and a greater focus on undetectable viral load between the studies could portend a shift of HIV prevention away from sexual practices towards medicalised notions of treatment uptake and adherence. While she acknowledges that this renewed focus on treatment has the potential to undermine the focus on the complex social aspects of the epidemic, she suggests that these processes could reframe serodiscordant sexuality as safe and legitimate, liberating and normalising serodiscordant relationships previously constructed as troubling or dangerous (Persson, 2016; Persson, Ellard and Newman, 2016). This shift to greater acceptability of TasP has also been seen in Philpot's study (2018) of men in same-sex serodiscordant relationships who were taking part in the Opposites Attract clinical trial (Bavinton *et al.*, 2018). An analysis of the risk reduction practices of couples in the study suggested that approximately half used condoms, approximately half relied on biomedical prevention approaches, including TasP and PrEP, with a small minority using strategic positioning (Bavinton *et al.*, 2019). Those that relied on TasP reported a sense of security that increased over time with repeated undetectable viral load results for the positive partner and continuing negative HIV tests for the negative partner (Philpot *et al.*, 2018). Other studies focus on potential risks of relying TasP alone as an HIV prevention strategy in a serodiscordant relationship, highlighting that partners' perceptions of viral load drive behaviour (Conroy *et al.*, 2016), but that positive partners who believe they have an undetectable viral load sometimes do not (Stephenson *et al.*, 2020). Given the importance of engagement with biomedical management in order to maintain an undetectable

viral load and also to provide this regular reassurance, Philpot (2018) proposes that couples who plan to rely on an undetectable viral load in their HIV prevention practices make an explicit agreement about such monitoring, which echoes recommendations made for men in same-sex relationships practicing negotiated safety (Crawford *et al.*, 2001). Although Philpot's recommendations are made for all men in serodiscordant relationships, Mitzel and colleagues (2019) found differences in patterns of treatment adherence in relation to the duration of serodiscordant relationships, highlighting the potential for changes in relationship dynamics over time to play a role in how TasP operates in an intimate context. Although these studies provide some insight into how men in same-sex serodiscordant relationships conceive of TasP and how this might vary between relationships, they place biomedical management at the centre of serodiscordant relationships while neglecting the meaning of those biomedical practices for the men who practice them and, I would argue, sanitising the 'messiness' of relationship intimacy. Later in this chapter, I will consider how a theoretical focus on the everyday can provide further insight into relationship intimacy.

In their introduction to a collection of global studies of serodiscordant relationships, Persson and Hughes (2017) highlight the need for research that presumes that experiences of serodiscordancy are inevitably bound up in a tension between positive and negative. Adopting an international focus emphasizes the situated nature of experiences of serodiscordancy and how it is mediated through cultural and social practices, of sexuality, gender and power relations. Serodiscordant relationships are patterned by socio-economic background and other differences, such as gender in heterosexual serodiscordant relationships, mediate relationship dynamics and how potential for transmission might be managed (Bourne, Owuor and Dodds, 2017). Considering serodiscordant relationships as patterned by the intersection of these social influences questions the implicit assumption underlying much of the

biomedical research, that there is a single, context-independent experience of serodiscordancy. Others argue that social research can provide an exploration of serodiscordancy that goes beyond a focus on risk management between couples, but can explore relational and cultural meanings beyond the couple domain (Newman, Persson and Ellard, 2018). I will explore the relationality of serodiscordancy, and the role of others outside the couple in this thesis, considering other sexual partners in Chapter 6 and friends and family in Chapter 7. These studies provide insight into how TasP has influenced a range of serodiscordant relationships and paint an optimistic picture in which serodiscordancy has become uncoupled from concerns of HIV transmission and the negative emotions associated with it. They also show the different ways that couples have engaged with TasP in order to justify their current sexual practices, or to engage with new ones. Yet while they provide a justification for disentangling serodiscordancy and transmission risk, these studies retain a focus on sexual practices in relation to HIV and neglect a broader consideration of the meaning of serodiscordancy in relation to relationship intimacy. This leaves an opportunity to examine how these relationships are constructed through other sociocultural influences. In order to deepen understanding of serodiscordancy, I will turn to theories that provide a framework through which to understand how the biomedical influences (and is influenced by) social processes and closely examine the way in which relationship intimacy functions in the everyday.

Conceptualizing biomedical transformations

Biomedicalisation theory describes the way in which the changes in the medical, technical and scientific spheres have combined to transform the ways in which medicine pervades the social world. It builds on earlier theories of medicalization, which focused on how medicine increased its influence over matters previously conceived as non-medical, but highlights the way in which these processes have become more complex and multidirectional in a

postmodern world (Clarke et al., 2003). Clarke and colleagues identify five processes through which biomedicalisation has come to operate: the privatisation and commoditisation of medicine and biomedical research, a focus on health rather than illness, new ways of generating and storing medical data, new ways of production and distribution of medical knowledge, and new ways of transforming bodies and identifying individuals. They highlight how the shift from medicalization to biomedicalisation has been accompanied with an overarching move from medical and social control over conditions to biomedicine effecting transformations of bodies and lives (Clarke et al., 2003). TasP has been framed as part of a wider biomedicalisation of HIV prevention and care that has transformed responses to HIV globally (Keogh 2017, Young 2016, Young 2019). Here I will focus on the implications of these processes of biomedicalisation for HIV and discuss how these will inform my analysis of serodiscordancy.

The focus of biomedical processes on health as well as illness encompasses the neoliberal responsibility of people to actively maintain their health and productivity as well as broadening of notions of illness to include 'at risk' states constituted through physiological and genetic surveillance and reference to standardized models. The pervasive nature of risk as constructed through biomedicalisation brings medical discourse into everyday life:

'It is no longer necessary to manifest symptoms to be considered ill or 'at risk.' With the 'problematization of the normal' and the rise of 'surveillance medicine' everyone is implicated in the process of eventually 'becoming ill' (Clarke et al., 2003, p. 172)

Even following ill health, the process of recovery now extends to further biomedical intervention, such as the cardiology patient 'at risk' undergoing 'aggressive secondary prevention' to reduce the risk of further heart attacks (Langdrige, 2016). In HIV, the uncertain nature of risk has led to the 'worried well,' particularly with relation to HIV testing (Davey and Green, 1991) and,

conversely to the need for new risk reduction strategies, such as PrEP, being contested (Young, Flowers and McDaid, 2016). Additionally, biomedicalisation theory can illuminate how the clinic insinuates itself into the intimate lives of serodiscordant partners. For example, through regular medical surveillance, testing for the positive partner's viral load, confirming the negative partners continued antibody status and regular screening for sexually transmitted infections for both. This regular flow of biomedical information has potential implications for partner's identities and relationship to each other and wider society as HIV prevention becomes more biomedicalised (Persson, 2016). While many trends in biomedicine serve to widen the scope of individuals 'at risk' and eligible for biomedical intervention, for example with PrEP, TasP problematises an individual notion of risk as it centres on the HIV positive partner. TasP alters previously established notions of HIV risk management, emphasising biomedical practices such as medication adherence and viral load monitoring and de-emphasising the importance of condoms in HIV risk management. The shift from visible, physical barriers to prevent HIV transmission to invisible biomedically mediated methods also makes risk management less tangible in the everyday, which has profound implications for partners in serodiscordant relationships, as I will explore in Chapters 5 and 6.

As well as bringing the biomedical into everyday life through risk, biomedicalisation theory describes how these processes allow the construction of identities in technoscientific terms or through the application of biomedicine. For example, genetic testing can identify individuals as carriers of an inherited disease, or the use of diagnostic tests can shift identity from 'healthy' to 'at risk' (Clarke *et al.*, 2003). The availability of a test for HIV antibody status in the 1980s led to the creation of HIV positive and HIV negative identities (Flowers, 2001; Young, Flowers and McDaid, 2016). In addition, previously unobtainable identities can be placed in reach through biomedical means, such as the role of 'mother' through the application of fertility treatment or support for HIV positive

women to have HIV negative children (Clarke *et al.*, 2003; World Health Organization, 2013). Clarke and colleagues also highlight how the new demands for self-monitoring associated with health promotion and neoliberal notions of individual responsibility for health can lead to new subjectivities, such as the proactive, prevention-conscious rational actor. This construction has been shown to underlie a body of HIV and sexual health promotion literature in the UK (Keogh, 2008a). Studies cited earlier show how men in serodiscordant relationships use biomedical information on serostatus, viral load and HIV risk to shape their sexual behaviour (Denning and Campsmith, 2005; Hoff *et al.*, 2009; Prestage *et al.*, 2009; Lampe *et al.*, 2012; Starks, Gamarel and Johnson, 2014). Davis and Flowers (2011) highlighted how men in serodiscordant relationships blended biomedical identities (positive and negative serostatus) with considerations of relationship dynamics to create new forms of relating, including exposure to HIV risk as an act of love.

Collin (2016) argues that pharmaceuticals influence biomedicalisation and biosocialisation through transforming binary or categorical variables into continua. Across a range of diseases rather than healthy/unhealthy, medicine has constructed varying degrees of health and risk. This modified view of health and illness is accompanied by a tendency within the medical profession towards intervention at an earlier stage; rather than starting statin treatment when a cardiovascular event has occurred, treatment is initiated in the presence of risk factors for the condition. This process can be seen in HIV, where negative individuals at risk of infection take the same treatments, in the form of PrEP, as their HIV positive peers. Although protected from the virus through biomedical technology, regular medication consumption and submitting to regular medical monitoring may bring the virus closer to an individual on PrEP's lived experience than other HIV negative individuals. Differences in attitudes and behaviours relative to HIV have already been described between HIV negative individuals who perceive themselves to have close proximity to the virus (through

experience with HIV positive friends and partners, or 'scares') and those who consider the virus a distant concern (Keogh, 2008b).

As well as providing opportunities for the formation of new social identities, biomedicine create new tensions in social conformity and resistance (Clarke *et al.*, 2003; Collin, 2016). As 'natural' states become medicalised and targets for treatment, they reflect and create new contestable social norms: shyness becomes 'social anxiety' and later 'social anxiety disorder' (SAD) in the psychiatric Diagnostic and Statistical Manual of Mental Disorders (DSM), effectively pathologizing social behaviour and making it a target of psychiatric and medical intervention. This transformation simultaneously provides opportunities for individuals to identify with the SAD label and form communities of support, and for alternative and opposed identities, such as 'introvert' to be created (Collin, 2016). The impact of TasP and PrEP has already been highlighted as disrupting social identities associated with HIV as a diversity of new biomedical possibilities, including 'undetectable' and 'negative on PrEP' have become available subject positions (Persson, Newman and Ellard, 2017; Rule and Slavin, 2017). Persson (2013, 2016) also shows how an 'undetectable' identity is resisted in by some and readily adopted in others, based on individual's existing notions of corporeal identity – 'embodied infectiousness' – and past experience. Although the transformation of identities has the potential to bridge the 'serodivide' and overcome the binary nature of social relations relating to HIV (Persson, Ellard and Newman, 2016) others point to the formation of new dichotomies that are centred away from positive/negative unsafe/safe but instead defined through boundaries drawn in relation to engagement with biomedicine (Guta, Murray and Gagnon, 2016). Although these transformations have been optimistically linked by the U=U campaign with a reduction in stigma, the possibility exists that instead a new class of deviance is defined in these terms, with those unengaged with testing and treatment a new underclass (Guta, Murray and Gagnon, 2016; Persson, Newman and Ellard, 2017). In Chapter 6, I

will examine how participants engaged with new identities associated with TasP in order to articulate new notions of sexual safety in their practices and relationships, but also how they engaged in boundary work to distinguish their practices from an unsafe 'other'.

Despite the widespread reach of biomedicalisation across many fronts, Clarke *et al.* highlight that these processes are not monolithic and unidirectional, but suggest that the changes they lead to are contingent, situated and negotiated. Thus, they have the potential to both perpetuate and address health inequalities, and to provide opportunities to address health-related stigma while simultaneously enabling new forms of discrimination and stratification (Clarke *et al.*, 2003). For example, a study on the imagined role that TasP will play in the future of people living with HIV highlights how changes of medical policy are not ultimately 'done to' individuals, but depend crucially on those the changes are aimed at, mediated through their past experiences, current situation and anticipated future (Keogh, 2016). The spread of biomedical technologies beyond immediate control over particular conditions to the transformation of lives is a key characteristic of biomedicalisation (Clarke *et al.* 2003) that has continued as new biomedicalised prevention technologies have developed. These processes are not deterministic but operate in dialogue with the communities that are affected by, and in turn affect, them (Young *et al.* 2016; Clarke *et al.* 2003). Thus the spread of biomedicalisation is not uniform, but depends on people making sense of technologies in their social context at the time. I will explore how participants experienced the biomedicalisation of HIV prevention and the transformations that are taking place and the role that their personal context and biographies played in shaping the meanings that they made. While biomedicalisation describes the social processes through which the biomedical transforms lives, these processes operate largely at the social level. In order to examine how biomedicalisation operates within personal spheres to transform intimate lives, I will explore sociological theories of intimacy, below.

Engaging with intimacy

A desire for sexual and emotional intimacy has been identified as complicating management of HIV risk in accounts of serodiscordant relationships (Green, Aggleton and Davies, 1995; Rhodes and Cusick, 2000; Doyal and Anderson, 2005; Jarman, Walsh and De Lacey, 2005; Davis and Flowers, 2011). In addition to understanding this aspect of relationship dynamics in more detail, a focus on intimacy is warranted in light of the broader 'intimate turn' in social scientific accounts of interpersonal relationships (Gabb, 2008). This section examines how intimacy has been theorised as transforming modern relationships and as a lens through which to view relationship practices. I will examine three theoretical approaches to intimacy described by Anthony Giddens, Lynn Jamieson and Ken Plummer, consider critiques of their positions and discuss how they can illuminate analysis of serodiscordant relationships.

In his work, *The Transformation of Intimacy* (1993), Giddens sought to explore the sexual revolution of the 1960s and describe what he saw as a trend towards the democratisation of modern relationships. In doing so he posits a form of sexuality, separated from its reproductive function, which he terms *plastic sexuality*. He traces the roots of the phenomenon to the late eighteenth century, when family sizes began to be limited, through to the availability of modern contraception and reproductive technologies. He credits this dissociation of sex and the procreative act with a gradual diversification in sexual expression, including non-reproductive sex and homosexuality. In parallel with plastic sexuality, he describes the transformation of couple relationships from reproductive contracts, bound up with and sustained through social, religious and moral expectations, to what he terms a *pure relationship*, in which the relationship is defined only in terms of what it brings to the people in it.

A pure relationship is one in which external criteria have become dissolved: the relationship exists solely for whatever rewards that

One of the factors which Giddens sees as crucial to the establishment of pure relationships is a move away from romantic love to *confluent love*. While he sees romantic love as a harbinger of modern forms of intimacy, containing as it does the notion of two people's attraction independent of social criteria, he rejects its place within the pure relationship due to its historical association with gendered power imbalances:

...romantic love is thoroughly skewed in terms of power. For women, dreams of romantic love have too often led to grim domestic subjection. Confluent love presumes equality in emotional give and take (Giddens 1993, p. 62)

The success of a pure relationship relies recursively on the satisfaction of both parties with the success of the relationship. Giddens suggests that this satisfaction is based on the extent to which the relationship can provide ontological security. In his thesis, this security rests on a sense of deep disclosure of self and knowing of the other. The success of a pure relationship rests on the satisfaction of each partner with the relationship. If this is cast into doubt by either partner, its future is placed in jeopardy, making pure relationships more fragile than earlier forms of intimacy.

In outlining this theoretical relationship structure, Giddens stresses the equality between partners such that each has an equal say in the terms and continuation of the relationship. To illustrate the concept, he cites examples from research into lesbian relationships, which he argues are closer than heterosexual relationships to the pure exemplar due the exclusion of issues relating to differences between women and men. In using this example, he highlights two issues that he sees with the pure relationship. Firstly, the lack of external references or models for their relationships for lesbians is cited as a barrier to achieving a sense of security; he suggests that women in these relationships felt they had to actively engage in making sense of the relationship and assess how

it should be functioning. The second relates to a contradiction at the heart of the pure relationship:

'To generate commitment and develop a shared history, an individual must give of herself to the other. That is, she must provide, in word and deed, some kind of guarantees to the other that the relationship can be sustained for an indefinite period. Yet a present-day relationship is not, as marriage once was, a 'natural condition' whose durability can be taken for granted short of certain extreme circumstances' (Giddens 1993, p. 137)

Thus, the lack of external references can provide freedom from expectations and can also lead to pure relationships lacking direction or sources of support. The precarious nature of pure relationships also provides a mechanism which reinforces equality within the relationship. Despite, in his view, fundamental differences between male and female sexuality, Giddens sees the fragility of pure relationships as an incentive for partners to aim to understand each other's needs. Giddens suggests the trend towards the equality inherent in a pure relationship is leading to a democratization of intimacy. He suggests that this has expanded beyond intimate couple relationships, drawing attention to recent changes in parenting style where children are viewed (and as far as possible treated) as equals. He paints a picture of a future where all personal relationships are conducted in an ethical framework that conforms to standards of emotional openness, equality and give-and-take. Giddens suggests that the greater communication demanded by such a framework will lead naturally to greater awareness of self, further supporting these relationships. The development of self-awareness is also, for Giddens, a goal of modern life, through the pursuit of reflexive identity projects (1993, p. 194).

Giddens's theorising on intimacy has been critiqued on several levels. In a paper published after *The Transformation of Intimacy*, Jamieson first argues that while Giddens portrays the transformations he describes as uniquely modern, the idea

that intimate relationships are becoming valued in their own terms can be found historically. She cites the example of Scottish Enlightenment philosophers who described friendships transforming from transactional interactions focused on mutual material benefit to bonds valued for the pleasure they brought. She also suggests that in proposing pure relationships, Giddens places too much emphasis on just one kind of intimacy, which she terms disclosing intimacy. This, she suggests, relies on uncritical engagement with a particularly individualistic view of relationships grounded in a psychotherapeutic paradigm which values introspection, self-knowledge and disclosure over other expressions of intimacy (Jamieson, 1999). She also criticises what she sees as an over-reliance on an optimistic reading of the potential of individualism as a positive force in social transformation and that Giddens's account does not sufficiently engage with established critiques which outline potential disadvantages of an individualist society.

A further critique of Giddens's account of the transformation of intimate relationships centres on his view of equality between partners. In addition to arguing that his theory does not outline anything new over the accounts of sociologists' accounts of family transformations from the 1950s, Jamieson highlights how these optimistic accounts paper over real, sustained social inequalities that continue to figure in intimate relationships (1998, 1999). These include significant asymmetries in contribution to domestic work between male and female partners, even in households where both partners have full-time jobs, supported by enduring gendered roles such as the 'male breadwinner' and housework being 'woman's work' (1998). In glossing over these concerns, Jamieson points out that Giddens fails to engage with a significant canon of feminist theory and critique of relationship structures. In the case of parent-child relationships, she questions whether the democracy that Giddens sees developing in this context is backed up with empirical evidence. She cites analyses of interactions between mothers and children of different classes,

showing that in working class families, presumptions of equality between parents and children are mostly absent. Furthermore, she outlines research which suggests that the desire for equality with their children expressed by many middle-class parents is belied by the content of their interactions: appeals for openness and honesty are interpreted by teenagers as parental surveillance, for example (1998, p. 73).

Turning to serodiscordant relationships, Giddens's concepts of plastic sexuality and confluent love can be seen in the sexual networks and open relationships described in studies of serodiscordant gay relationships (Prestage *et al.*, 2008; Hoff *et al.*, 2009; Hoff and Beougher, 2010; Hosking, 2013). Similarly, partners within a relationship setting and agreeing their own relationship terms, often with a commitment to disclosure of outside sexual activity could be argued to be an instance of the radical disclosure Giddens sees as crucial to the maintenance of pure relationships. However, serodiscordant relationships provide another instance in which Giddens's notion of radical equality can be questioned. In the accounts of individuals in serodiscordant relationships, the biomedical asymmetry in HIV status is translated into different rights and responsibilities within the relationship: positive partners often feel an obligation to protect the health of their partner and prevent viral transmission at all costs and can be held responsible for exposing them to risk, even if an instance of unprotected sex was initiated by the negative partner (Cusick and Rhodes, 2000; Davis and Flowers, 2011; Persson, 2013).

In addition to these critiques, I would argue that in assuming that lesbian relationships can be used as an example of particularly equal (and therefore 'pure') relationships and analogous to heterosexual bonds, Giddens adopts a simplistic view of same-sex relationships as ungendered, ignoring feminist and queer approaches to relationships and intimacy. He also discounts the potential for social discourses to influence the formation and dissolution of relationships; heterosexist discourses which construct homosexual relationships as less valid

or, in the case of serodiscordant relationships, biomedical discourses which privilege HIV negative serostatus (Davis and Flowers, 2011). As Heaphy and colleagues (2013) argue, we should be wary of viewing same-sex relationships only through the lens of equality and creativity (and conversely heterosexual relationships only along gendered lines). They point out that relying on these 'socially given' lenses of gender or equality can result in overly unsophisticated analyses of agency and power in relationships and, in doing so, overlook social changes which are reconfiguring marriages, gender, heterosexuality and homosexuality in different contexts. Instead, they urge the exploration of relationships in their own right, situated within a context of changing practices and meanings. Applying this logic to same-sex serodiscordant relationships invites a focus on the relationship itself as the unit of examination, in the context of a changing biomedical context rather than an analysis which breaks down experiences along lines of serostatus (see Chapter 4).

In their analysis of same-sex couples who had entered into civil partnerships in the UK, Heaphy and colleagues found that these couple relationships were linked to, but not determined by participants understandings of other 'ordinary' relationships. In drawing on these models, the relationships they studied did not follow a script, but were dynamic and emergent, as participants navigated the conventions, constraints and choices inherent to their situations. Heaphy and colleagues draw attention to the way in which convergences and contradictions arise in these accounts between freedom to experiment and convention and link these to broader social reconfigurations which are leading to new ways of 'doing' social relationships. They also argue that in some circumstances, claiming to be ordinary is a political act and that in doing so, their participants are both drawing on and resisting conventional senses of marriage and relationships (Heaphy, Smart, Einarsdottir 2013, Heaphy 2018).

In her critique of Giddens, Jamieson outlines a more grounded way of describing and evaluating intimacy, focusing on empirical research into relationships as well

as cultural discourses. In doing so, she highlights the historical contingency of different accounts of intimacy, examines conflicting accounts offered in private and public spheres and discusses some of the ways in which people in intimate relationships reconcile these differences. Most of all, she questions the notion that there is one dominating form of intimacy and draws out evidence that supports practical caring and sharing as important considerations in intimate relationships alongside notions of disclosure and deep knowing (1998, p. 13). Outlining the evolution of marital and parental intimacy in the pre-modern and modern eras, Jamieson cites conflicting examples which call into question any theory seeking to trace a linear transformation: experiences of relationships vary over historical periods, by class and by individual circumstances. For example, she illustrates how the role that fathers play in parental relationships has at different times and in different circumstances followed and resisted changes in public discourses about motherhood and fatherhood: in some families, fathers continue to play a traditional emotionally distant but financially supportive role; in others, circumstances such as unemployment lead to some men taking a more hands-on approach to childrearing. Some men embrace traditional images of masculinity to justify their treatment of intimate partners, others react against them to adopt 'new male' roles in their relationships (1998, p. 129).

Continuing the focus on how relationship intimacy is construed through practices, every day, seemingly mundane, activities can be perceived as loving gestures: offering an unasked for, but appreciated cup of tea made in just the right way not only embodies care but also empathy and understanding (Gabb and Fink, 2015a). Linking these practices to Hochschild's gift giving economy within relationships can illuminate the way in which social mores can inflect intimacy. For example, socially held norms around gender roles mean that while a husband taking on additional childcare responsibilities may be valued as a gift to his partner, her doing the same would likely already form part of her routine role and thus have lower 'value' (Gabb, 2008). This 'affective economy' is also

sustained and supported through emotional labour, for example, demanding gratitude from a woman in an otherwise equal partnership:

An equalitarian couple in a society that as a whole subordinates women cannot, at the basic level of emotional exchanges, be equal.

For example, a woman lawyer who earns as much money and respect as her husband, and whose husband accepts these facts about her, may still find that she owes him gratitude for his liberal views and his equal participation in housework. Her claims are seen as unusually high, his as unusually low.

(Hochschild, 2012)

Viewing serodiscordant relationships through the lens of relationship practices, a positive partner's daily pills and regular blood tests in order to maintain an undetectable viral load can be considered alongside other practices that sustain the relationship and constituted as acts of care (Savage, 2017, p. 21). Similarly, seronegative partners' use of unprotected sex to demonstrate commitment can be understood with other gestures as expressions of trust and acceptance of their positive partners (Rhodes and Cusick, 2000). Applying notions of gift giving highlights how the social value of negative status makes this action meaningful, whereas the converse offering would not normally be accorded the same value, and is instead actively avoided (Davis and Flowers, 2011). The contingency of this evaluation is highlighted by the existence of alternative (not to mention controversial) narratives of 'bug chasing' and 'gift giving' in which and HIV positive status is valued and the virus becomes a gift that can be conferred on negative partners (Grov and Parsons, 2006; Hammond, Holmes and Mercier, 2016).

In her analysis of sexual intimacy, Jamieson highlights that the elision of intimacy and sexuality is culturally contingent. She outlines some evidence that is consistent with Giddens's description of the rise of confluent (rather than romantic) love and instances where female sexuality has become freed up from

norms of romance and reproduction, but also draws attention to cultural discourses – those common to discussions of rape and sexual violence, for example – where old models of women are expected to defend their virtue while men are expected to make sexual advances (1998, p. 111). Similarly, she questions the degree to which plastic sexuality is a realistic representation, discussing the persistent definition of sex as penis-in-vagina penetration in sex education and safer sex narratives and the differing attitudes and expectations among men and women towards sex (1998, p. 112).

Both Giddens and Jamieson provide accounts of intimacy which primarily trace changes that have occurred in the recent past and interpret the present, with some speculation on implications for the future. They also focus much of their argument on heterosexual and traditional family relationships, with scant discussion of alternative sexualities. Giddens and Jamieson also describe a Western – and in Giddens's case, middle-class – reality and while Jamieson draws out on the role of cultural influence in expressions of intimacy, neither appears to consider how intimacy could be realised differently in other settings. In his account of the transformation of intimacy, *Intimate Citizenship*, Plummer (2003) instead focuses on what he sees as the diversification and plurality of intimacy which has begun to emerge and focuses on how they might support more varied expression in the future. He suggests that 'the grand narrative' of intimacy is not a concept which can be used to understand the post-modern world, enumerating the interacting influences which show signs of disrupting ways of relating, including the media and on-line communication, bio(medical)technology, and globalisation, marketization, and the growth of insecurity and destabilization (2003, p. 20). Mobilising the term 'citizenship' in intimate citizenship and in the related concept of sexual citizenship brings forth the way in which issues situated at the heart of personal life are structured through the broader social communities in which we are situated (Plummer, 1995; Weeks, 1998; Gabb, 2008). Conceptually uniting the public and private in

this way emphasises the way in which the division between these spheres has been shown to be a false dichotomy. Although both intimate and sexual citizenship provide the tools to examine the way in which the personal and the public interact, given the need to move beyond an analysis of serodiscordancy in terms of sex and risk, I have preferred intimate citizenship as it encompasses the totality of intimate experience.

In intimate citizenship, the possibilities offered by greater freedom of expression of sexuality and gender interact with technology, communication and global cultural flows to create new sites and forms of intimacy. These include new forms of relationships, different definitions of family and parenting, new understandings of gender and sexual expression. In doing so, he considers how the personal and public spheres might interact to support or resist these new forms. These have interacted through moral conflicts to produce new social realities, such as the creation of the lesbian and gay community and the notion of 'gay rights' (2003, p. 36). This is reflected in how serodiscordant couples are working with the opportunities afforded by TasP to publicly tell their stories, which they had previously silenced due to concerns of stigma. By highlighting new ways of 'doing' serodiscordant relationships and making public previously private intimacies, serodiscordant couples can articulate a new form of intimate citizenship which could ultimately help to bridge the 'serodivide' that separates HIV positive and negative individuals in wider society (Persson, 2016). It is perhaps ironic that rather than supporting new forms of intimacy, treatment is constructed by some in serodiscordant relationships as allowing a sense of normality and sameness with other couples (Koester, Erguera and Myers, 2017). A key focus of this thesis is to focus on everyday experience in order to articulate how participants are 'doing serodiscordancy' and tease out where new intimacies are emerging, where more traditional relationship ideals are being drawn on and, indeed, to bring out the complexity serodiscordant intimacy.

In a late modern world producing opportunities for more and more different

ways of living, and new intersecting identities, Plummer identifies the dissolving of traditional ethical frameworks as a threat to the continuation of this process, with a greater potential for conflict between contrasting citizen groups. He argues for the need to create structures that nurture and maintain a commitment to dialogue, even between groups with diametrically opposed views and for a new morality, admitting of ambivalence in the place of old certainties. He proposes grounding discourses of morality in the stories of people facing up to and negotiating the dilemmas they meet in their everyday lives (2003, p. 115). Citing research into different groups' experiences as a key way of documenting and analysing these stories, he proposes an 'intimate citizenship project' with the aim of encouraging investigation into the creation of new intimacies, public spheres and approaches to intimacy and the moral conflicts and dialogues they provoke, as well as the concrete experiences and moralities of everyday life (2003, p. 142). Applying this lens to experiences of serodiscordancy brings to light the way in which participants navigated their sexual practices in the context of biomedical transformation to articulate new notions of (ir)responsibility, as I will discuss in Chapter 6.

In outlining this theory, Plummer acknowledges several tensions and limitations inherent in his thesis. One of these includes how to account for groups that actively resist notions of rights and responsibilities and wish to operate outside notions of citizenship within a framework that intends to capture the diversity of human experience. Linked to this, he recognises that there may still be limits to the application of citizenship to some groups, such as paedophiles, although he also suggests that the discomfort associated with such a notion may itself be an important factor in the negotiation of new moral structures. He is also concerned that his theory of intimacy does not become a new all-encompassing narrative which simply replaces old monolithic approaches to morality. In his call for dialogue between clashing intimacies, Plummer recognises a tension when two viewpoints are based on diametrically opposed principles – the right of women

to choose an abortion over the right of the developing embryo, for example. He acknowledges that such dialogues are unlikely to be comfortable, but cites the example of processes through which 'pro-choice' and 'pro-life' groups have identified common ground and reach agreement on core principles. However, he is unable to provide a mechanism through which groups can be brought into a dialogue they refuse to participate in. He also admits that his account draws heavily on experiences from Western liberal democracies and is contingent on human rights and political freedom for its expression. He argues that the existence of such inequalities strengthens the need for further research and action to address the exclusion, marginalization and powerlessness that is the backdrop to many experiences of intimacy (2003, p. 145). Similarly, for serodiscordant relationships the optimistic tone struck in recent analyses of the potential for treatment to tackle stigma and facilitate new forms of intimate citizenship are contingent on the availability of effective treatments, which is not a given for all people living with the virus. The asymmetry of responsibility for viral protection and assumed superiority of HIV negativity can be manifest as power imbalances, leading to coercion and emotional abuse in serodiscordant relationships (Wyatt *et al.*, 2012; Savage, 2017).

The different approaches to understanding intimacy described here – from Giddens's description of a new self-referential ways of relating, Jamieson's descriptions of the strategies used by individuals to bridge the gap between relationship ideals and reality, to Plummer's account of the diversifying ways in which new forms of intimacy are being formed – provide a varied and sometimes contradictory framework to examine close relationships. However, they all reveal tensions between experiences in private spaces and public discourse and highlight the relevance of theories of intimacy to explicating serodiscordant relationships.

Summary

Here I have summarised key biomedical and social developments that have taken place in HIV management over the past 30 years and shown how the HIV landscape has been and continues to be transformed. I have examined studies of serodiscordant relationships across 'eras' of HIV risk management and shown the different ways in which they have been constructed: as demanding intensive practical and emotional support; as problematic sites of transmission risk; and most recently as productive of new forms of intimacy and optimism. In addition to the differences in the framing of serodiscordant relationships, I have outlined the differing epistemologies that underpin the research agendas of each literature. I have considered how the initial social scientific response to the AIDS epidemic has led to a significant body of research taking place through a public health lens and have discussed critiques of this paradigm, which focuses on behaviour and emphasises individual cognitive processes at the expense of understanding the social context and the influence of other social determinants. In order to situate these studies within wider bodies of research, I have considered biomedicalisation theory and the processes of transformation that it describes the biomedical having on society. In particular, the potential of biomedical developments to be productive of new identities and to transform social roles. Consistent with the review of past transformations of HIV risk (see Chapter 2), I have described how biomedicalisation operates to transform existing social forms and these are thus predicated on what has come before. I have drawn links between existing studies of serodiscordant relationships and their findings and outlined how further research could provide additional insights into the influence of biomedical technologies on serodiscordant relationships. In order to further understanding of serodiscordant relationships as intimate phenomena, I have also reviewed sociological theories of intimacy. In particular, I have focused on theories that foreground practices of intimacy and understanding of how people 'do' relationships, arguing that such an approach

illuminates serodiscordant relationships further. Finally, as well as considering how the social influences the intimate, I have also used Plummer's theory of intimate citizenship to argue that the intimate also influences the social. I have argued that bringing these two bodies of theory to bear on serodiscordancy invites a nuanced analysis of this phenomenon, not only as a site of influence of the biomedical but also as one of active meaning making through a complex entanglement of the social, the biomedical and the intimate. In doing this, I have highlighted an opportunity to contribute to understanding of serodiscordant relationships in the era of TasP through a study which steps back from the close examination of risk and its negotiation and examines serodiscordant relationships in their own right, focusing on the intimate practices that constitute them and how these are inflected through biomedicalisation.

4. Methodology and methods

*The working process is one of discovery and it is worth remembering
that the word 'discovery' implies an uncovering of that which is
hidden*

Bridget Riley (2019)

We don't see things as they are; we see them as we are

Anais Nin, Seduction of the Minotaur (1961)

Writing about the experience of viewing Riley's works, Elderfield (2001) discusses the associations that occur to him as he views the painting and how these intertwine with his perception of the colours and forms to create a combined representation. Yet, rather than random associations, Elderfield suggests that these representations are 'more properly recognitions, identifications discovered in the experience of the painting, not thoughts that stray.' Riley discusses how her work produces what she refers to as 'the recognition of the sensation, *without* the actual incident that prompted it' (Elderfield, 2001, p. 15). This recalls Van Manen's explanation that phenomenology is 'interested in recovering somehow the living moment of the 'now' or existence – even before we put language to it or describe it in words' (Van Manen, 2016, p. 57). Writing about the practices through which she develops her paintings, Riley discusses the way in which the works are developed through a series of decisions about fundamental elements, like structure, colour and scale. She also draws attention to how, although her method relies on 'conscious intuition' in making these decisions, its success relies on the rigour with which she pursues her work.

In this chapter I will discuss how, inspired by phenomenology, this thesis seeks to examine the vital, fleeting sensations of the lived experience of

serodiscordancy. I will outline my working process and key decisions, including how I drew on hermeneutic phenomenology alongside the principles of thematic analysis in order to articulate an inquiry that traces the way in which the social impinges on serodiscordant intimacy. Finally, working within an epistemological framework that holds that all meanings are situated and contingent, highlights the importance of reflexive engagement with the data and throughout the research process. In the second part of this chapter I offer a reflection on my position within the study.

Research approach

This section situates the phenomenologically informed approach I adopted within overarching theoretical and epistemological debates and frameworks, in order to support the methodology and methods I deployed.

As outlined in Chapter 3, an existing body of psychological research on serodiscordant couples has sought to define 'risk behaviour', quantify this behaviour and identify factors that predict it, in order to develop preventative interventions. The mainstream psychological approach is guided by a positivist epistemology, which hinges on defining and measuring variables to test hypotheses relative to an assumed objective reality (Potter, 2006; Langdridge, 2007; Clarke *et al.*, 2010). In contrast, the aim of this project is not to explain behaviour with reference to psychological constructs, but to gain insight into the experiences of research participants, how they make sense of these experiences and what meanings they attach to them. It also aims to examine how their experiences and sense-making relate to broader factors, in terms of HIV biomedicalisation and social processes more generally. This approach draws on a critical epistemology which emphasises the subjective and situated nature of knowledge, highlighting the way in which knowledge claims are socially constructed and supported (Potter, 2006; Clarke *et al.*, 2010). This approach conceives of multiple knowledges produced through interaction between

participant and researcher. For this reason, I refer to 'data generation' rather than 'data collection' and have included a discussion of my own position in relation to the research.

As my review of the literature has shown, understandings of risk and infectiousness are often at the core of people's everyday experiences of serodiscordancy and of HIV (Rhodes and Cusick, 2000; Persson, 2008; Davis and Flowers, 2011; Mendelsohn *et al.*, 2015; Persson, Ellard and Newman, 2016; Daftary, Mendelsohn and Calzavara, 2017; Koester, Erguera and Myers, 2017; Philpot *et al.*, 2018). Therefore, the changes that have taken place in biomedical prevention of HIV and the resulting transformation of the risk landscape have the potential to transform those experiences. Indeed, this is a core contention of the U=U campaign. Rather than take these transformations as read, my focus on the everyday points to the importance of returning to ordinary experiences of serodiscordancy in order to grasp the impact of TasP. The inadequacy of previous psychologically based explanations for serodiscordant sexuality and the radical shift in the potential for embodied experiences of HIV point me away from an externally imposed scientific framework focused on risk and towards a study of participants' lived experience in their own terms. In addition, Keogh and Dodds (2020) highlight the way in which personal narratives are 'flattened' in the public discourse of U=U. They suggest that using personal frames of reference can bring out more nuanced accounts of the way in which biomedical notions of infectiousness are navigated in intimate relationships. In adopting a focus on everyday intimacies, I intend to provide a further counterpoint to public, biomedical narratives relating to serodiscordancy.

These epistemological considerations are further bolstered by my commitment to the primacy of experience in developing sociological accounts and a personal commitment towards social justice, coupled with a distaste for explanations that potentially pathologize and stigmatise sexuality and serodiscordant relationships. In their study of civil partnerships, Heaphy and colleagues (2013)

highlighted a potential double bind when studying same-sex relationships. On one hand, they subscribed to the argument made in an earlier anthropological study of heterosexual marriages (Mansfield and Collard, 1988) that emphasised the need to make the ordinary strange in order to get beyond common sense 'givens' about relationships. On the other, they were wary of the opposite: assuming that the relationships they were studying stood apart from 'ordinary' partnerships (Heaphy, Smart and Einarsdottir, 2013). In this study of same-sex serodiscordant relationships, the challenge centred on being able to plot a course between notions of exceptionality and the ordinary. To be able to move beyond narrow conceptions of serodiscordancy as being about HIV risk management, but also to question opposing assertions about their relationship's normality. The importance of putting to one side these two sets of assumptions drew me to a phenomenologically informed method.

Methodology

For reasons outlined above, I adopted a phenomenologically informed thematic analysis for this study. Phenomenology is the study of human experience, as it is experienced without reflection or attempts to conceptualise or categorise it (Van Manen, 1990, 2016). My approach was inspired by the hermeneutic phenomenological method of Van Manen (1990), which has been used widely in health and clinical psychology and places analytical emphasis on uncovering the meaning of experiences (Langdridge, 2007; Larkin, 2015).

Finlay (2006) outlines four characteristics of the hermeneutic phenomenological approach: a commitment beyond science and towards the humanities, explicit use of interpretation, reflexive acknowledgement of the researcher's involvement and placing emphasis on expressive presentation through writing. In having a commitment beyond science, Finlay suggests that hermeneutic phenomenologists aim to think in terms that apply to the lived human world and allow the multiple layers of experience to be revealed. The need for

interpretation in this approach is due to the concern of phenomenology with meanings which are often implicit or hidden. This drawing out of meaning from lived experience contrasts with other approaches which are more inclined to impose an external frame of reference in order to provide an explanation. The practice of phenomenology involves both description and interpretation; hermeneutic phenomenology particularly emphasises the role of interpretation in its investigation of experiences. Although it retains a commitment towards systematic, methodical study of human phenomena, through its commitment to interpretation, a hermeneutic approach invites more poetic renderings of experience (Finlay, 2011; Van Manen, 2016). The aim of this approach is to thematise experience through evocative language and to understand it through a variety of lenses (Finlay, 2011).

Phenomenology sits as both a theoretical foundation for and a methodological approach to research into human experience. Through its various methods it encompasses both description and interpretation (McWilliam, 2012). Compared with other forms of enquiry, this approach, 'shifts our focus from things and nature to human beings and their lived worlds and from explaining to clarifying' (Giorgi, 2005, in McWilliam, 2012, p. 229). It argues that through careful examination of lived experience, we can come to gain deeper understanding of the things presented to us in those experiences (Sokolowski, 2000). Phenomenology traces its roots from the German philosopher Edmund Husserl, who initially began a project to found science on the basis of certain knowledge, with direct experience as this foundation. Although this objective was later abandoned, through his theorizing about the way in which our experiences and consciousness are structured, Husserl developed concepts and techniques which form the foundation of the pursuit of phenomenological investigation. He argued that in order to attend to experiences themselves, it is necessary to adopt a different mode of engagement with the world. Husserl termed this the *phenomenological reduction*, a return to 'the things themselves' (Van Manen,

2016, p. 91). Instead of focusing on experience as we do in the day-to-day, we should focus on the experiences of those things: 'looking at what we normally look through' (Sokolowski, 2000, p. 50). In order to achieve this stance, it is necessary to 'bracket' our 'natural attitude' towards the world and to suspend these everyday beliefs. Instead, phenomenology requires that we focus on the phenomena in and of themselves. The concept of the phenomenological reduction has been modified and developed by subsequent phenomenologists but remains at the core of phenomenology (Van Manen, 2016). While Husserl initially proposed a transcendental approach that brackets foreknowledge and attitudes, later phenomenologists have recognised the impossibility of achieving this state. It is this later body of work that informs this study. This subsequent body of literature has argued that Husserl focused too intently on cognitive clarity and in doing so overlooked the practical, situated nature of being. Instead, they suggest that, recognising we remain beings embedded in the world we wish to study, phenomenology should involve achieving an attitude towards the world that helps us to 'break our familiar acceptance of it' (Merleau-Ponty, 1962, p. xiv). In practice, Van Manen (2016) suggests that the phenomenological reduction is sustained through a sense of 'wonderous attentiveness' to the subject under study. Through this stance, it is possible to bring into focus aspects of meaning which are otherwise hidden or are made invisible in our everyday engagement with the world. Drawing on phenomenology in this study invites reflection on the lived experience of serodiscordancy without reference to the epidemiological, medicalized frames which have underpinned previous studies.

By explicitly focusing on the researcher's interpretation, hermeneutic phenomenology draws attention to and embraces researcher and participant subjectivity as well as the context in which these inter-subjectivities are produced. Finlay describes researchers engaging in a 'solo waltz... moving in and out of (pre-reflective) experience and reflection' as the researcher engages

multiple meanings emerging from the data (Finlay, 2006, p. 1). Focusing on meaning emerging in this way also draws attention to the context in which the participant, researcher and research as a whole are embedded. This further emphasises the co-creation of data and research findings by both researchers and participants in the context of an intersubjective research encounter. As with other qualitative methodologies, phenomenology acknowledges the role that the researcher plays in the creation of knowledge with participants. Although in adopting the phenomenological attitude, hermeneutic phenomenologists attempt to extricate themselves from their own perceptions and understandings in order to examine experiences as they occur in the lifeworld, they also recognise that this can never be completely achieved and thus the influence of the researcher's lifeworld should be acknowledged (Finlay, 2011). Recognising this, as outlined later in this chapter (see *Analysis, Reflexivity*), I set out to capture and interrogate my own reflections during the data generation and analysis from the outset. In a recent reflection on their development of thematic analysis, Braun and Clarke (2019) add a further dimension to considerations of reflexivity in qualitative analysis. In addition to the personal, situated reflexivity described above, they point to the importance of researchers being aware of and reflecting on their broader epistemological and ontological assumptions and how these are captured as part of the research process:

Reflexive thematic analysis (TA) needs to be implemented with theoretical knowingness and transparency; the researcher strives to be fully cognisant of the philosophical sensibility and theoretical assumptions informing their use of TA; and these are consistently, coherently and transparently enacted throughout the analytic process and reporting of the research. Braun and Clarke 2019, p 594

This highlights the creative role of the researcher in the analytic process, generating, constructing and developing themes, rather than them 'emerging' as more 'mechanistic' accounts of thematic analysis. With these joint considerations, I therefore not only present in this chapter an account of my own

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position, but also a description of the way in which I engaged with these methods in order to complete the analysis presented in subsequent chapters.

Adopting a phenomenologically-informed thematic analysis raises the question of why I did not undertake one of the many phenomenological methods available to researchers in health and wellbeing. Occupying as broad and ambiguous space as it does, phenomenology has been labelled as one of the more confusing methodologies used in health research (Tymieniecka, 2002a, in McWilliam, 2012). This confusion may be behind Van Manen, one of the leading proponents of hermeneutic phenomenology, bemoaning the profusion of research which purports to be phenomenology but which, in his assessment, falls short of being a *true* phenomenological reflection (Van Manen, 2017). Van Manen suggests that the hallmarks of a phenomenological enquiry are not only a deep engagement with human experience of a phenomenon, but also the deployment of particular phenomenological techniques. Although I was inspired by phenomenology's interrogation of everyday experiences beyond the surface, I was not seeking to create a singular evocative account of the experience of being in a serodiscordant relationship, but rather to explore the meanings participants ascribed to their relationships and the role that TasP played in those meanings. With this aim in mind, a full phenomenological analysis as outlined by Van Manen would not be necessary and a more exploratory phenomenologically informed approach, such as described by Rosenblatt and Wieling (2019), is more appropriate. In an account of their study, *Knowing and Not Knowing in Intimate Relationships* (Rosenblatt and Wieling, 2013), they discuss the ways in which Van Manen's hermeneutic phenomenology was deployed in conjunction with a thematic analysis of data. In common with their approach, I combined elements of hermeneutic phenomenology with a search for themes which provide insight into serodiscordancy. In contrast with Rosenblatt and Wieling's more open approach, I was guided by the framework for thematic analysis outlined by Braun and Clarke (Braun and Clarke, 2006; Braun, Clarke and Terry, 2015; Braun et al.,

2019), who provide a method-driven guide to the process of analysis. Their framework offers structure combined with flexibility which means it is compatible with a range of epistemological approaches. This flexibility was helpful given my use of theoretical frameworks drawn from different disciplinary literatures and my desire to incorporate elements of a phenomenological approach to analysis.

Participants

Individuals living in the UK who identify as male and gay or bisexual, and in an established serodiscordant relationship with someone who identifies as male, were invited to participate in the project. No minimum duration of relationship or other criteria were specified in relation to participants' relationships, allowing for 'relationship' to be defined in participants' own terms. Participants from relationships with more than two primary partners were eligible for inclusion in the study. The HIV status of participants was based on self-report and was not verified serologically. Defining participation criteria in terms of self-identification avoided imposing categorisations on relationships but involved some limitations; for example, this study did not include relationships where HIV positive participants had not disclosed their status to their partners and those who do not self-identify as gay or bisexual. An additional limitation related to participants' sexual and gender identities: other than confirming that they met the study criteria (i.e., identified as a gay or bisexual man), participants were not asked to further specify their self-identity, which prevents this study from exploring aspects such as bisexual and cis identities, for example.

In total, 30 individuals, representing 20 different relationships, participated in the research (see Table 1). Seventeen participants reported being HIV positive, thirteen reported being HIV negative. Participants were aged between 23 and 76 years old and were currently in a relationship with a man of different HIV status to them. All but two of the participants had been educated to degree

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level or above and had white-collar or professional jobs (see, *Sampling* below). Outside of those necessary to support the purposive sampling strategy, no other demographic details were collected from participants. As a result, participants' ethnic, religious and disability identities cannot be systematically reported. However, during interviews participants discussed biographical details that speak to the relative homogeneity of the sample. For example, twenty-one participants reported being born in the UK, six were born outside the UK in English-speaking countries, and three participants were born in non-English speaking countries but had lived and worked in the UK for several years.

Participants were recruited through community support organisations, personal networks and advertising in targeted community publications and venues, on-line forums and social media (see *Recruitment*). Two participants were interviewed in South of England and four were interviewed in the North of England, the remainder lived in or around London. In recognition of their contribution to the research, and in line with Open University policy (see *Ethics*) participants were offered a £20 Amazon voucher after their participation had been completed.

Participant quotes are associated with pseudonyms based on lists of common names. Participants were randomly allocated pseudonyms from a list of popular English boys' names in the last century, with the exception of participants whose names originated in different cultures, who were allocated pseudonyms drawn from lists of common names from those cultures. Following the example of another study which interviewed couples together and apart (Gabb and Fink, 2015a), quotes from couple interviews are associated with a different pseudonym in order to reduce the potential for cross-referencing and support confidentiality.

Table 1: Participant demographics

HIV status	Age	Education	Occupation
Negative	41	Postgraduate	Office worker
Negative	51	Postgraduate	Office worker
Negative	23	Postgraduate	Student
Negative	37	Undergraduate	Office worker
Negative	45	Postgraduate	Student
Negative	55	Undergraduate	Office worker
Negative	32	A-levels	Retail worker
Negative	43	Undergraduate	Creative industry worker
Negative	51	Postgraduate	Office worker
Negative	43	Undergraduate	Office worker
Negative	36	Undergraduate	Office worker
Negative	46	Undergraduate	Creative industry worker
Negative	58	Undergraduate	Retired
Positive	48	Postgraduate	Student
Positive	41	Postgraduate	Office worker
Positive	39	A-levels	Healthcare worker
Positive	42	Undergraduate	Office worker
Positive	40	Undergraduate	Creative industry worker
Positive	76	Postgraduate	Retired
Positive	30	Undergraduate	Office worker

HIV status	Age	Education	Occupation
Positive	63	Postgraduate	Retired
Positive	30	Undergraduate	Office worker
Positive	60	A-levels	Retired
Positive	58	Postgraduate	Office worker
Positive	34	Undergraduate	Creative industry worker
Positive	61	Undergraduate	Creative industry worker
Positive	46	Postgraduate	Office worker
Positive	33	Postgraduate	Student
Positive	26	Postgraduate	Student
Positive	32	Undergraduate	Office worker

In three couples, the HIV positive partner was diagnosed before the availability of HAART in 1996. In eight couples the positive partner was diagnosed after 1996 but before 2010, when HPTN-052 and the first evidence of TasP became available. In the remaining nine couples the HIV positive partner was diagnosed after 2010. All the diagnosed participants were engaged with medical care and were taking antiretroviral medication. Although HIV positive participants' viral load was not a criterion for study inclusion, it emerged during interviews that all HIV positive participants had an undetectable viral load at their last consultation. This reflects the current UK picture of HIV treatment, in which almost all people diagnosed with HIV are receiving treatment and have an undetectable viral load (O'Halloran *et al.*, 2019). When the couples became serodiscordant was not selected for in sampling and was not systematically monitored, but during interviews it emerged that 13 relationships began as serodiscordant. In six

couples, both partners were aware of the serodiscordancy when the relationship began, in the remaining seven the positive partner told their negative partner about their HIV status after the relationship had begun. The remaining seven relationships began as seroconcordant and later became serodiscordant. The differences in these initial experiences of serodiscordancy are discussed in Chapter 7.

Recruitment

Recruitment began in July 2017 and was completed in April 2018, when data saturation had been reached. In line with the urban nature of the epidemic in the UK, recruitment focused on urban areas in the north and south of England (Kirwan et al., 2016). Participants were recruited through personal networks, via flyers and posters distributed in gay community venues in London and Manchester, printed adverts placed in a publication circulated weekly in gay venues in London (see Figure 2), digital adverts on Facebook and Scruff targeted to gay and bisexual men in London and Manchester and via social media. Social media recruitment was carried out by establishing a profile for the research (named You±Me) on Facebook, Twitter and the geolocation dating app, Scruff. Scruff was selected because of its policy of providing free banner advertising to non-profit organisations, my familiarity with the app and informal feedback that it had a higher proportion of users in relationships than alternative apps. On Facebook and Twitter, posts containing information about the study were created and shared through the site. Further information about the study was published on a public blog, including a list of 'frequently asked questions' and my contact details for any questions about participating. A short screening questionnaire consisting of eight questions was developed in Qualtrics in order to assist potential participants assess their eligibility to participate in the research. The link to the questionnaire was added to the blog page and was completed by 14 potential participants.

Figure 2: Recruitment postcard



In total, 72 potential participants expressed an interest in participating in the research. Thirty-nine participants learned about the research from social media (27 via Scruff, six via Twitter and six via Facebook). Twenty learned about the research from advertising in community venues, three learned about the research through personal networks and 10 participants were approached to take part in the research by their partner. Of these potential participants, three were ineligible to participate in the research (one female, one living outside UK, one no longer in a serodiscordant relationship). The remaining 69 participants were sent an information sheet about participating in the research via e-mail and asked to send back demographic information. Participants who did not respond were sent a maximum of three follow-up messages, those who requested not to be contacted further had their personal details deleted. Thirty participants returned demographic information, gave their consent and participated in the research. One additional participant consented to take part in the research but did not respond to three follow-up messages to arrange an interview and was not included in the study, no other participants dropped out from the study or later withdrew consent to participate.

Recruiting sufficient participants took longer than initially anticipated. After low interest with initial recruitment methods and few initial expressions of interest becoming confirmed participation, additional routes of recruitment were

explored, including additional recruitment activities through community groups in London and Manchester. At this stage, I adopted a more proactive recruitment approach on Scruff, switching from banner advertising on the app to setting up a profile and sending a message introducing the research and recruitment criteria to participants who stated on their profiles that they were in a relationship. Although I linked the Facebook and Twitter profiles I created for the study to my personal profiles on those sites, I used a logo I created for the project as the profile image for these profiles. Based on norms for users of the app, and my understanding of behavioural science (Michie *et al.*, 2013), I included my photo on the profile I created for the study, holding up a postcard advertising the study. This direct approach garnered most expressions of interest, although few of this number ultimately participated (see Table 2).

Table 2: Recruitment methods

Method	Expressions of interest	Confirmed participants
Social media	39	12
<i>Facebook</i>	6	2
<i>Twitter</i>	6	4
<i>Scruff</i>	27	6
Community outreach	20	9
<i>Advertising</i>	9	3
<i>Community group referral</i>	11	6
Personal network	3	1
Partner referral	10	8
Total	72	30

The high attrition rate between expressions of interest and participating in the study, particularly through on-line methods is notable. The published literature on attrition in qualitative research is sparse and largely concerned with participation across longitudinal studies (e.g. Marcellus, 2004). However, why potential participants choose to take part in research or not is complex and can indicate concerns about participant safety or researcher insensitivity towards vulnerable groups (Boynton, 2017). An early encounter with a potential participant sensitised me to the potential for the research to be stigmatising to those in serodiscordant relationships, which led me to carefully consider how I framed the study and created recruitment materials (see Appendix G). The use of social media and the internet to recruit participants is in its relative infancy and novel issues such as the completion of on-line surveys by bots (Godinho, Schell and Cunningham, 2019; Stephenson *et al.*, 2019) are being encountered by researchers. In this context, the low cost of expressing potential interest through social media or on-line may lead to lower conversion rates to active participation than response to other forms of recruitment which involve a more active decision to participate, such as by sending an e-mail or making a phone call. It is notable that the recruitment method with the least attrition, partner referral, was also the one associated with the strongest social commitment (see Table 2).

Initially, I planned only to recruit participants whose partners also consented to take part in the research in order to facilitate examination of the relationship as the unit of analysis. After difficulty in recruiting participants (described above) and feedback from several potential participants whose partners did not wish to take part, this criterion was relaxed in November 2017. Thereafter individual participants whose partners were unable or unwilling to participate themselves were included in the study. This trade-off increased the potential pool of participants, but reduced opportunities for couple interviews.

Sampling

Purposive sampling was employed with the aim of recruiting participants across cohorts according to time since the HIV positive partner was diagnosed and social class. Time since diagnosis was selected to provide a range of experiences across biomedical eras of HIV treatment. Social class was monitored as it is associated with a wide range of social inequalities in health, economic and cultural indicators (Savage et al., 2013). Socioeconomic status has also been shown to interact with health and relationship quality, including HIV-specific outcomes (Harrison et al., 2008; Tieu et al., 2011; Hardie, Geist and Lucas, 2014). UK national surveys of gay and bisexual men have consistently reported a higher prevalence of HIV infection in working class men (Hickson et al., 1999, 2001, 2003; Reid et al., 2001; Keogh, Dodds and Henderson, 2004; Reid, 2011). Although this evidence suggests that an assessment of social class would be relevant to this study, precise definition and delineation of class remains controversial; different taxonomies suggest a range of social classes defined by different demographic and social measures, ranging from occupation to main modes of cultural consumption (Savage et al., 2013). In addition to this, definitions of class are complicated by questions of self-identity which resist classifications reliant solely on demographic measures (Gabb and Fink, 2015a). This study followed other research (Hickson et al., 1999, 2001, 2003; Reid et al., 2001; Keogh, Dodds and Henderson, 2004; Reid, 2011) in defining class through measures of education and employment collected from participants. For the purposes of this study, 'working class' was operationalized as participants who had not attended higher education and were employed in manual, casual or blue-collar work. As discussed later in this chapter, recruitment of working-class participants was planned through distribution of materials in a wide range of commercial and community venues, including those with a predominantly working-class clientele and through engagement with community organisations whose client base included working-class individuals (see *Recruitment*). However, in the end only two of the 30 participants met the criteria I used to

define 'working class'. I have discussed the challenges posed by recruitment and how I responded to the slow accrual of participants by relaxing the criteria for inclusion in the study. In addition to a slight change in emphasis in the way in which the study sample was structured, the slower rate of recruitment also meant that my plans to recruit purposively in order to acquire a diverse sample were also unrealised. As a result, this thesis represents the experience of a homogenous group in terms of class, meaning the range of experiences that are represented in the data set are accordingly narrower. This extended to relationships practices, with all participants being in couple relationships and other relationship formations being unstudied.

Data generation

The data in this study were generated through individual semi-structured interviews (n=28), supplemented with 6 couple interviews which included participants from the individual interview sample. Interview data were generated between August 2017 and April 2018. Interviews were flexibly organised, based on participant and researcher availability and the availability of a suitable location for the interview to take place.

Individual interviews

Individual interviews focused on each participant's experiences of their relationship and specifically of serodiscordancy. They were guided by an interview schedule which consisted of three sections, one section on past experiences of relationships and HIV, one section on their current relationship, relationship practices and experiences of serodiscordancy, and a final section focusing on their sexual relationship and practices. To support privacy and a focus on intimate practices, interviews were held in participants' homes. However, recognising that not all participants would wish to be interviewed at

home (Gabb and Fink, 2015a), they were given the option to be interviewed in a private third-party space (for example, local community organisation spaces or Open University premises). Four participants did not cohabit and nominated one house to be interviewed in. Four participants were interviewed away from their homes in local community settings. On several occasions, participants who lived together were interviewed sequentially in a single visit. When this occurred, I reminded participants of the confidentiality of each other's interviews and agreed steps, such as the partner not being interviewed moving to another part of the home or going out, to minimise the chances of being overheard. All interviews were electronically recorded, backed up with hand-written notes that I took during interviews in case of equipment failure. One participant requested that the final section of the interview focusing on sexual practices was not audio recorded and data for this section of the interview consisted of my written notes alone.

To ensure the appropriateness and usability of the methods, draft interview guides and materials were reviewed for acceptability by two gay men with experience of serodiscordant relationships who had expressed an interest in participating in the study but were ineligible (due to their location or because they were no longer in a serodiscordant relationship). The interview schedule was reviewed following the first pair of interviews and updated following an initial review of the transcript of the interviews. Recognising the high proportion of immigrants to the UK within the population living with HIV for whom English is a second language, provision was made in the deployment of methods for alternative data gathering formats, such as audio diaries and use of elicitation materials in interviews (Einarsdottir, 2012). In the end, all men who participated in the study were fluent in English and this provision was not required.

Couple interviews

A criticism of some studies of families and relationships is that they do not

engage with all members of the relationship or family unit (Gabb, 2008) and are therefore unable to provide insight into participant interactions and relationship processes in the same way as those which move beyond individuals are able to (Jamieson, 1998; Gabb, 2008; Heaphy and Einarsdottir, 2013; Bjørnholt and Farstad, 2014; Gabb and Fink, 2015b). Although it has been argued that ethical and confidentiality considerations necessitate interviewing couples separately, others suggest that involving both partners of in the research encounter together produces rich accounts of relationships that cannot be achieved through individual interviews (Bjørnholt and Farstad, 2014). In a study of recent civil partnerships, Heaphy and Einarsdottir (2013) advocated interviewing participants together and apart, in order to gain an understanding of how a relationship is co-constructed and the connection between this and the individuals' attitudes towards relationships as part of their individual biographical trajectory. In the context of serodiscordant relationships, a review of studies found that many enrolled only one partner (Mendelsohn *et al.*, 2015). This approach may have been adopted to simplify recruitment, but limits the potential of these studies to examine processes between partners. A recent qualitative study of serodiscordant relationships enrolled both partners from several couple relationships, and one three-partner relationship. Individuals whose partners were unable or unwilling to participate in the research were also included so that their experiences were also available for analysis (Persson *et al.*, 2016). These considerations informed my initial plan to recruit couples (see *Recruitment*, above) and my later decision to retain an optional couple interview for interested participants.

Couple interviews (n=6) were conducted in a second, separate research encounter. In order to minimise the potential for breaches of confidentiality between individual and couple interviews (see *Ethics*) couple interviews were structured around third person scenarios. Participants selected and discussed pre-printed cards containing topics relating to different aspects of long-term

couple relationships, including physical affection; sex and drugs; children and pets; money; friends and family; social media; HIV and antiretroviral treatment; general health; media and politics (see Appendix F).

Diaries

To supplement the data generated in interviews, I initially planned to invite participants to complete a diary in advance of their individual interview. Diaries can operate to shed light on what happens when the researcher is not present, as well as bringing into focus events that are seemingly inconsequential and this can provide insight into how participants frame the everyday (Gabb and Fink, 2015a). Particularly in studies of intimate relationships, diaries can also function as 'confessional devices' (Harvey, 2011) and this can further open up the ways in which couples ordinarily invest in and maintain their relationships.

Instructions were provided to participants who kept diaries on what kind of entries to make over the course of a week, including: reflections on time spent together or apart from their partner; things, events or people that made them think about their relationship; good and challenging moments; times when serodiscordancy was brought to mind. An open format was adopted in order to allow participants to respond to salient events rather than the structured accounts of activity that have been used in earlier diary based studies of sexuality and relationships (Phellas and Coxon, 2012). Participants were offered the choice of producing written diaries in hard copy or electronic format. In addition to written entries, participants were invited to include objects in their diaries, such as mementos of time spent together (cinema tickets, receipts, etc.), newspaper clippings, or pictures and photos.

Diaries were used by the first four participants to write about their relationship experiences over the course of a week. One participant completed a handwritten journal, three completed their diary entries electronically. No participants

provided additional materials, although one submitted screenshots of his and his partner's WhatsApp messages during the week. No participants completed their diaries in advance of their interview and three of the four participants provided theirs only after several follow-up requests over two weeks. Feedback from these participants centred on the difficulty of remembering to complete diary entries each day, and the onerousness of the task. Based on this feedback and the high rate of attrition in the recruitment process, during which the use of diaries was explained, I made a pragmatic decision to simplify participation and exclude diaries from subsequent data generation.

As a result, diary data forms a small proportion of my total data set and I have therefore not sought to draw contrasts between data generated via different means in this analysis. However, to ensure that I acted ethically, all the data were used: the handwritten diary was transcribed and electronic diaries were imported into NVivo for coding and analysis alongside participant interview data (see *Analysis*). Having diary data from these four participants, generated while I was 'away', provided some insight into everyday moments of intimacy and sexual intimacy, which did not appear in initial individual interviews. As these were the first participants in the study, this gave me the opportunity to include more specific probes about these moments in the interview schedule (see Chapter 6: *Negotiating serodiscordant sexual practice*). My awareness of these data sensitized me to potentially 'hidden' moments in subsequent interviews, which I was able to notice and explore in more detail than I would have without the insights from the diary data. The role played by the data from the small number of diaries collected in flagging lines of interest and investigation during analysis suggests that there could be more gained from further study. In order to support the collection of diary data, alternative techniques and digital technologies that support participants to generate diary data and share it with researchers could be deployed (Palen and Salzman, 2002; Anhøj and Møldrup, 2004).

Ethics

Research ethics is often operationalized as a 'box ticking exercise' to achieve sign-off from an ethical review body, or how to avoid issues that have arisen in previous research (Boynton, 2017). Characterizing research ethics in this way risks both oversimplifying ethical considerations and making them a consideration only during the initial set-up of the research process. Ethical issues can arise not only during the conduct of the research itself, but also during the dissemination and publication of research (Lee, 1993), underlining the importance of engagement with these considerations throughout the research process. Viewing research ethics as a static 'rubber stamping' process also elides the dynamic and emergent nature of ethical issues, particularly in research on sensitive subjects (Lee, 1993). In research on sensitive subjects, adhering to ethical guidelines alone may not be sufficient to ensure that the potential risks of research to participants and researchers are mitigated (Dickson-Swift, James and Liangputtong, 2008). In addition, researching relationships can also lead to complexity around the ethics of reporting data generated with multiple related participants. While cross-referencing data from multiple sources can provide richness and depth to analysis, this needs to be balanced against issues such as the potential identifiability of participants (Gabb, 2010). In order to respond to these challenges in this study, I not only undertook formal ethical approval (see next section) but also reflected on the ethical dimensions of the study throughout (see *Reflexivity*). This not only led me to adopt particular approaches to participant anonymity and data reporting, but also, during the process, to reflect on the emergence of sensitivity about the conduct of the research itself. In particular, I reflected on how through making serodiscordancy a subject of study, while processes of normalization were at play (see Chapter 5), there was the potential for the research itself to be perceived as stigmatizing (see Appendix G).

Formal ethical approval for this study was provided by The Open University

Human Research Ethics Committee (see Appendix B) and the study was conducted in accordance with the British Psychological Society (BPS) Code of Human Research Ethics (British Psychological Society, 2009). As with other research on sensitive topics, additional care was taken to address the balance of harms and benefits of the project, including reviewing research materials for acceptability with potential participants in advance of their use. In addition, participants were provided with information signposting appropriate sources of social and psychological support after the research was concluded (see Appendix C).

In qualitative social research, paying participants is recognised as potentially complicating consent to participate, with criticisms focusing on the potential for coercion or corruption relating to remuneration (McKeganey, 2001; Head, 2009). However, these concerns need to be balanced against pragmatic considerations around participation and offering proportionate incentives, deployed sensitively during the recruitment process, can support participation and appropriately recognise participants' contribution to the research (Boynton, 2017). Open University guidelines provide for reimbursing participants' travel expenses and reasonable compensation for their time and involvement. Participants were offered a £20 Amazon voucher on completion of their interview in recognition of their time and participation in the study. The amount and format of payment was selected in line with similar studies carried out at The Open University.

Consent

Participants were fully verbally briefed on what their participation in the project would entail and their right to withdraw participation at any point during the research process, along with a written information sheet. Participants' consent to participate was documented in writing and renewed verbally at appropriate points during the research. During the briefing process, care was taken to ensure

participants understood that the research was not intended as a therapeutic intervention, although participants in similar studies have reported a positive impact on their relationship from research participation (Gabb *et al.*, 2013).

Confidentiality

Data gathered during research were stored securely on a password protected computer, backed up on a password-protected folder on The Open University OneDrive, access to which was not shared with other Open University users. Transcripts were anonymised with pseudonyms (see *Participants*) and other potentially identifying information was replaced during transcription. To assure the confidentiality of individual interviews, participants are identified in the research report using different pseudonyms for individual and couple interviews. No serious concern regarding the safety of participants or others was encountered during the conduct of the research, so there was no cause to break confidentiality (British Psychological Society, 2009).

Analysis overview

In this section I provide an account of the analysis which forms the substance of the following three chapters. As outlined in previous sections, I adopted a phenomenologically orientated thematic analysis of the data generated in interviews. This approach has been adopted by other researchers on similar topics, such as openness in relationships (Rosenblatt and Wieling, 2019). In contrast with other methods, such as Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2009) or Grounded Theory (Grbich, 2013), there is not a codified method for the analytic process I adopted. Therefore, following Barbour's (2019) approach to theoretically led analysis, I drew on different methodologies as resources to make use of, rather than rigid templates to dictate process. In pursuing this approach, I drew on elements from Van Manen's

hermeneutic phenomenology (Van Manen, 1990, 2007, 2016), and Braun and Clarke's framework for thematic analysis (Braun and Clarke, 2006, 2019; Braun *et al.*, 2019). Although the process of analysis I undertook shares many commonalities with IPA (Smith, Flowers and Larkin, 2009), I did not closely follow Smith's recommendations, and I have therefore not labelled it as such. As with all qualitative analyses, analysis was an iterative, recursive process which at times seemed messy and, in many ways, resists a systematic account. Instead I have drawn on Braun and Clarke's six-step structure for a thematic analysis and will discuss where and how I made use of the principles of phenomenology within this framework.

Familiarising myself with the data

Guides to carrying out qualitative analyses emphasise the importance of researchers first familiarising themselves with their dataset and how the process of transcription can aid in this (Braun and Clarke, 2006; Smith, 2008; Braun *et al.*, 2019). I transcribed all individual interviews and one couple interview myself; the remaining four couple interviews were professionally transcribed by a university-accredited service in the interests of time. I reviewed the professional transcripts for accuracy, completing sections that had been flagged as unclear by the transcriber. As I was not completing discourse or conversation analysis, I used the verbatim transcription convention, rather than more in-depth orthographic forms, as this more closely matched my analytic needs (Edwards, 2014). Following transcription and transcript checking, I read and re-read the transcripts, making marginal notes on participant's experiences and highlighting sections which were particularly relevant to the research questions. At this stage, with the objective of familiarisation in mind, I did not attempt to 'bracket' my own experience and perceptions, drawing from and adding to the impressions that I noted in my research journal during the interview process.

Van Manen (2016) emphasises the importance of writing to the analytic process

and, with this in mind, I prepared short 'pen portrait' summaries of the first few participants whose transcripts I reviewed. In preparing these summaries, I engaged Van Manen's holistic approach (1990, p. 93) focusing on capturing the main significance of each transcript as a whole, summarising events that participants described which seemed to be particularly meaningful for their relationship. Through this process, I began to familiarise myself with the meanings that participants attributed to their relationships and to serodiscordancy. This helped to inform the subsequent stages of analysis. In order to sensitise myself to participants' feelings, beliefs and the emotional content of the data in this initial stage, I also used the 'I poem' technique (Edwards and Weller, 2012), generating short 'poems' consisting of the 'I feel...' statements contained within the transcript, presented in order. In using these techniques I did not engage the phenomenological tool of bracketing to attempt to suspend my personal and emotional reaction to the phenomena described in the data, but through using them I started the process of engaging with 'the data as data' (Braun *et al.*, 2019).

These processes helped me to move towards a deeper engagement with the experiences and meanings of serodiscordancy. As I began to examine the data in this way, I focused closely on participants' individual experiences noting patterns across the sample; although the HIV status of participants was recorded during recruitment and is noted where data extracts are shared, I analysed the data as a whole, rather than separating experiences into participants who were seropositive or seronegative. Although there are elements of experience which are uniquely associated with the different serostatuses, my aim in this analysis was to examine the experience of serodiscordancy – of difference – as a relational phenomenon, rather than providing an analysis which described what it is like to be HIV positive and have a negative partner (and vice versa). Through this process of transcription, reading, summarising and reflection, I developed a deep familiarity with participants' accounts and was able to recall and locate

particularly salient experiences and features of each interview within the volume of transcripts.

Generating initial codes

The second stage that Braun and Clarke outline in their guide to thematic analysis involves the process of identifying features of interest to the researcher and producing codes to label and organise these features. As thematic analysis is compatible with a number of disparate approaches to analysis, they distinguish between inductive (or data-driven) and deductive (or theory-driven) coding practice (Braun and Clarke, 2019). In line with phenomenology's commitment to examining experiences as far as possible without intervening theory – turning to 'the things themselves' (Van Manen, 1990, 2016) – I initially adopted an inductive approach to coding the interview data. I worked systematically through the transcripts and allocating codes to extracts of the data which referred to similar recurrent meanings across the data set. This process involved a closer, more detailed reading than the holistic approach in the familiarisation phase. In addition, I took inspiration from Van Manen's detailed reading approach (1993, p. 93), working through transcripts line by line and asking what each sentence, or cluster of sentences revealed about the experience of being in a serodiscordant relationship. I also combined this with his selective reading approach (1993, p. 93) in which I marked passages that seemed to be particularly revealing about the experience of serodiscordancy; many of these passages later formed the basis for themes within the analysis. I used NVivo (NVivo for Mac) qualitative analysis support software to manage the process of reviewing and annotating transcripts with codes.

In their account of carrying out a phenomenological thematic analysis, Rosenblatt and Wieling (2019) deconstruct the idea that the main work of coding takes place in one stage of the research. They distinguish between 'formal' and

'informal' coding and highlight the relationship between earlier phases of the research process, such as forming research questions and creating interview discussion guides, and the eventual 'formal' work of classifying and labelling of aspects of data as of interest. By drawing links between the different phases of the research process they emphasise the way in which analysis, rather than being a single distinct phase, is embedded within the whole research project itself. Rosenblatt and Wieling's account brings out how decisions made by researchers earlier in the design and execution of a project shape and texture the data that is generated through it; even if in analysing it we attempt to suspend our usual mode of engagement with the phenomena described within it during analysis, the data themselves are steeped in the practical, personal and theoretical decisions which formed them. Although the idea that a pure phenomenological reduction - a 'view from nowhere' - is not practically possible, and more recent scholars of phenomenology have reformulated and recast the phenomenological reduction in terms of 'suspending everyday attitudes' (Van Manen 2016). While coding, I approached the data with the phenomenological reduction in mind and focused closely on what I perceived to be happening in the data for participants. As discussed above, while I did not attempt a full 'bracketing' of my prior experience, I put to one side the social theories of intimate practices and biomedicalisation, seeking to engage with participants' accounts on their own terms. During this process, I noted my own reactions to the data and the resonance between participants' accounts and my own experiences. As I note later (see *Reflexivity*) managing my emotional reaction to the data was challenging and because of this, the process took longer than I had initially anticipated. Recognising and reflecting on these reactions from my coding was a difficult process, but one which helped me both to manage my reaction to the data and to approach coding from a standpoint which supported the process of 'making strange' the data by reflecting deeply on my reaction to the phenomena being described. Returning to the coded data and using NVivo to view similarly coded passages together, out of the context of the whole

interview transcripts, further helped me to focus closely on the coded data extracts and suspend my experiences of, and assumptions about, the participants that I had formed during the earlier stages of the research project.

Searching for themes

In thematic analysis, Braun and Clarke define a theme as something that captures 'something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set' (Braun and Clarke, 2006). Whereas in a thematic analysis, the themes form the product of the analysis, from a hermeneutic phenomenological perspective, themes represent intermediate tools in the process of reflection, which will ultimately result in the production of a phenomenological description of the subject of analysis (Van Manen, 2016). Rosenblatt and Wieling (2019) also view themes as particular points of meaning and importance in the data, but in line with their 'deconstructed' view of analysis, conceive of them as reflecting not only the data itself but also the researchers' particular interests in the topic under examination. In line with this view of developing themes, I reflected how the process of this analysis began informally before data had been gathered, through framing research questions and creating discussion guides to gather richest data, grounding study in existing literature and sensitising myself to methodologically and theoretically relevant lenses for analysing and interpreting data. In the development of themes, these considerations included a focus on everyday practices, in which I aimed to capture detail that participants might otherwise consider too mundane to mention, and a focus on sexual practices, which participants may not have brought up without specific and sensitive questioning. In seeking to interrogate patterns in the codes that I had generated, I began to organise them together graphically, plotting a mind map of different but related elements of data. Initially I organised these themes into three broad overlapping clusters (see Figure 4), which related to broadly what the codes were

about - about relationships, about safer sex and HIV and about the biomedical. I further grouped the initial codes I had generated within and between these clusters to further organise the codes and generate initial themes. At this stage, I decided not to take forward into themes a number of codes that I had developed which were not specifically related to serodiscordancy, for example, general experiences of HIV care.

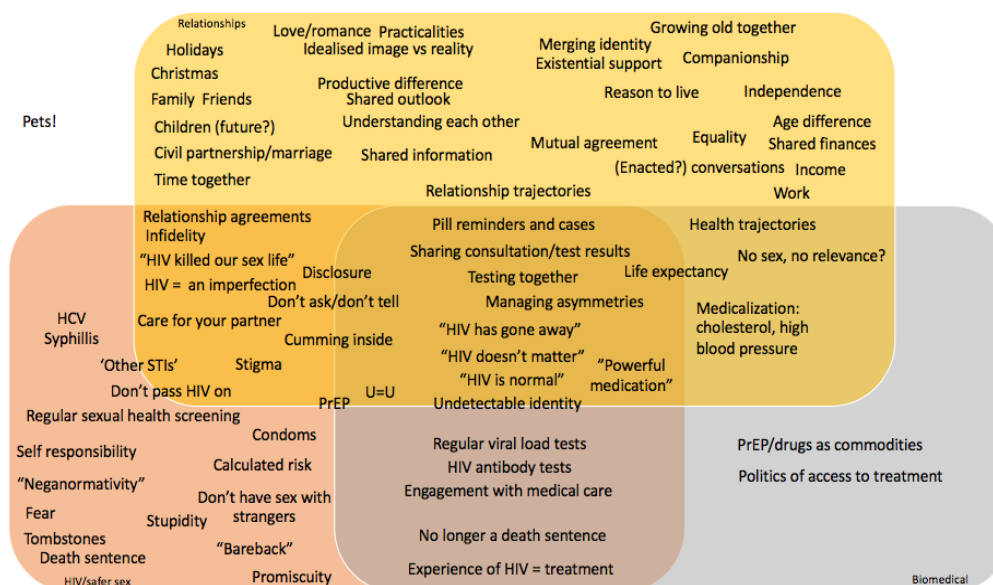


Figure 4: Clustering codes graphically to generate themes

Reviewing themes

During the process of developing and refining themes, I regularly reviewed the coalescing themes and framework of clusters in which they sat. Through this process I continued to refine and adjust the content of themes. I informally discussed my findings with other students and university colleagues to help refine themes and found this particularly helpful in highlighting areas which were complex or difficult to explain. Similarly, preparing 'work in progress' conference presentations and posters focused on one or two themes in development played an important role in 'solidifying' portions of the analysis, bringing together data extracts in a meaningful way and communicating them to an academic audience.

Packaging and presenting elements of data in this way further progressed the process of bringing together the 'naive' codes and themes generated in a data-led approach with 'top down' literature and theoretical lenses. Through these activities, I was able to clarify, affirm, challenge and modify the themes I developed in order to strengthen the analysis.

Defining and naming themes, producing the report

Recognising the iterative nature of analysis, Braun and Clarke acknowledge that although their framework places writing up at the 'end' of a process, suggesting that this stage implies the analysis has been finished and has simply to be 'written up' this step is often only one part of a longer process of revision and further refinement. Similarly, throughout his writing on hermeneutic phenomenology, Van Manen (1990, 2007, 2016, 2017) emphasises the importance of writing to the analytic process, arguing that in many ways writing *is* the analytical process. With this in mind, I have combined the final two stages of Braun and Clarke's framework, as the process of writing up the analysis has been an integral part in the process of defining and refining the analysis. Rosenblatt and Wieling (2019) also highlighted how knowing that the final output of the process would be published as a book influenced the way in which they carried out their analysis. Being aware of constraints of length of the write-up, and therefore the depth of information that they would be able to present, helped to guide and structure the analysis as it progressed. Similarly, with my write-up, the endpoint of producing a thesis that would constitute an original contribution to the field, structured around an estimated 3-4 findings chapters, helped me to focus particularly on groups of themes which resonated with the established literature and theoretical framework.

As I began writing up, I noticed how the structure of the original interview schedule continued to pattern the themes that I was developing. While

Rosenblatt and Wieling (2019) present the creation of an interview schedule as itself an analytic act, a close correspondence between themes and interview questions has been highlighted as a potential hallmark of poorly done or insufficiently rigorous thematic analysis (Braun and Clarke 2006). This prompted me to further review the themes I was developing and to bring out phenomena within the data which cut across interview sections and drew on data which were generated across the interview schedule. Returning to my initial analysis in this way allowed me to build it up by bring in additional concepts. For example, I returned to phenomenological principles, looking holistically at the themes I had developed and considered how these were united by common experiences. I also drew on other principles outlined in phenomenological analyses, such as temporality (Van Manen 2016), and considered experiences relative to when they occurred around the relationship.

Organising themes into chapters and selecting excerpts to illustrate themes also highlighted the need for adjustments. I combined themes that drew on similar excerpts to make similar points and removed others which, although potentially interesting did not include enough data or link closely enough to other themes to support a substantive chapter section. During this process I went back and forth between the general and particular, paying close attention to nuances of the data in order to solidify codes and themes. For example, the original codes 'HIV has gone away' 'HIV doesn't matter' and 'HIV is normal' have, in the process of writing up been combined and are presented as different aspects of the same theme, forming the core of a chapter in their own right (see Chapter 5). By close examination of the data which supports them, and a reflection of the meaning of the phenomena being described, it became clear that superficially similar codes were drawing on very different standpoints and could be understood through different theoretical lenses. When to conclude an analysis can also be a complex question, but in this instance the pragmatic considerations of completing a thesis within a specific word count and to a schedule governed by

university regulations provided a limit to the process that I undertook. However, considerations of completeness of an analysis can be linked to its quality, which I will consider now.

A criticism levelled at qualitative research in the past has been that in the open and flexible way in which analysis is carried out there is an impression that 'anything goes' (Braun and Clarke, 2006). In fact, Braun and Clarke argue that the flexibility of qualitative approaches and applicability of methods such as thematic analysis across a range of epistemological positions demands that qualitative researchers are aware of and make explicit the assumptions underpinning their research that may be taken as read in other disciplines. Criticism also centres on the way in which analysis relies intrinsically on the individual or group who has performed the analysis. If analyses rest on the interpretations of an individual researcher, which in turn depends on their own lived experience and context, how can any analyses performed in this way be reliable or replicable? Rosenblatt suggests that concerns about the replicability of analyses show how qualitative social sciences continue to be 'haunted by scientific objectivity' (2006). He argues that criticisms of qualitative analyses which question the objectivity or relation to truth of their findings are invalid. However, the question of how to distinguish good analysis remains. Van Manen (2016) emphasizes the importance of the reader in questions of quality. He points out that successive phenomenologists have investigated similar phenomena and have indeed drawn different conclusions. Rather than casting into doubt their reliability, he argues that they emphasise different aspects of the experience. Although different analyses may draw out different aspects, the quality of the analysis rests on providing insight into a phenomenon which resonates with the reader.

Braun and Clarke suggest that considerations of rigorousness of method and trustworthiness of findings are at the forefront when judging the quality of analysis (Braun and Clarke, 2006). Drawing on this perspective informed my

decision to provide a detailed account of the process of my research in this chapter in relation to the guidelines that they provide. Braun and Clarke also point out that although providing guidelines for conduct of analysis can help, they are neither sufficient nor necessary for a high-quality analysis (Braun and Clarke, 2006, 2019). Instead, they emphasise the involvement in others from the academic community or those with an interest in the phenomenon being examined in ratifying the findings. Eschewing a scientifically informed notion of replicability, I did not employ cross-checking of coding with another analyst. Instead, I have highlighted the role that discussing the analysis and sharing 'work in progress' with others has helped guide the content and conduct of the analysis. This was also furthered through formally presenting and getting feedback on different aspects of the analysis at academic conferences with different disciplinary audiences (see Appendix H) and at community group meetings.

In this section I have provided a detailed account of the processes I undertook in order to complete the analysis which I present in the subsequent chapters. In the spirit of Braun and Clarke's reflexive approach to thematic analysis, I have discussed not only the steps that I undertook, but how I engaged with the data in different ways through the analysis and how I drew on ideas and concepts from phenomenology as I did so. I continue the reflexive engagement with this research in the next section, taking into account my personal position and experience of both generating data through interviews and producing the analytic themes.

Reflexivity

Phenomenologically-informed research places particular emphasis on the role of the researcher in the co-creation of research data (Finlay and Gough, 2003; Langdridge, 2007). Researchers working with couples on sensitive topics have reflected on the emotions, such as embarrassment, elicited during interviews

and how the interaction with participants led to meaning emerging in particular ways (Einarsdottir, 2012). In order to ensure that my experiences from the research process were available for analysis and reflection, I kept a research journal during the data generation phase and wrote memos during analysis in order to capture and reflect on my experience of the processes. Researcher reflexivity, that is reflecting upon the way in which the researcher themselves is involved in the creation and conduct of the project, is widely recognised as a vital part of qualitative research. Recognising the power inherent in the research process, any social analysis which neglects reflexivity has been argued to be 'fundamentally incomplete' (Bonner, 2001). However, the question of how to go about 'taking responsibility for what one says' with a reflexive account is a challenging one. Finlay and Gough (2003, p. xi) acknowledge how presenting accounts of reflexivity that are at times complex, confusing and messy without falling into 'a vortex of narcissism, pretentiousness, or infinite regress,' is difficult balance to strike. In this section I will briefly overview different approaches to reflexivity before offering some observations and insights from my own reflexive practices during the research.

Why reflexivity

Finlay (2006) suggests that in its various guises, reflexivity can be a tool through which researchers can examine the way in which the position, perspective or presence of the researcher affected the research and can provide deeper insights into interpersonal dynamics and personal responses to the research. She also points to its role in uncovering previously unconscious motivations or biases within the researcher's approach as well as the opportunity it presents to empower by offering access to more radical consciousness. Finally, reflexivity may also play a role in the evaluation of research and its outcomes, as well as enabling scrutiny by acting as a methodological log of the research and the decisions that shaped it (Finlay, 2002a, 2002b). She is critical of conceiving of

reflexivity as a tool to provide 'truthful' methodological accounts that affirm the validity of research, arguing that this deployment of reflexivity rests on positivist ideals; rather, reflexivity provides researchers with a method to embrace the negotiated and constructed nature of the practice of research. In this way, the subjectivity of the research process is transformed from a problem to an opportunity (Finlay, 2002b, p. 531). Viewing reflexivity in this way, she argues, can show how the researcher is imposed all the way through the research process and can help to bring out complex political or ideological agendas that could otherwise remain hidden. Nevertheless, reflexivity can prove to be problematic. The process of introspection, drawing on the researcher's own voice, may eventually overshadow the experiences of participants or draw the focus of research away from the phenomena being studied. Once again, she highlights the challenge of finding a balance between meaningful deconstruction and nihilism. She reminds us that reflexivity should be 'neither an opportunity to wallow in subjectivity nor permission to engage in legitimised emoting' (Finlay, 1998, p. 455) and challenges reflexive researchers to use these processes of introspection as a springboard for interpretations and insight rather than an end in itself.

The varying relationships between a researcher, the subject they are examining, and their participants has sometimes been summarised by researchers positioning themselves as 'insiders' or 'outsiders', depending on their own lived experience and relationships. Focus has been given to the methodological challenges of engaging in insider research, alongside the potential for additional insights potentially available to an insider researcher (Greene, 2014). Conversely, the benefits of a fresh perspective and openness to interpretations less grounded in personal experience have been suggested as benefits of 'outsider' research. However, Thomson and Gunter (2011) point out the limitations of this binary distinction in a reflection on their involvement in research conducted in schools, in which they highlight the multiple and fluid relationships between

them as researchers, their participants and the conduct of the research. Researching in a school as former teachers, they describe their experience of different aspects of their experience and role coming to the fore at different times and being positioned in different roles by the assumptions and actions of participants at different stages of the research. This shifting relationship reflects my own experience of conducting this research, being conscious of different at times of different aspects of my identity coming to the fore – as a researcher, as a volunteer who educates about HIV prevention and sexual health, as a sexually active HIV negative gay man, as someone in a civil partnership.

Reflexivity in this study

During interviews I did not explicitly state my personal position in relation to the subject of the research, sharing only that I was studying at The Open University and did not bring up my sexuality, HIV status, or relationship status. I sometimes hinted that I had experience of same-sex relationships during interviews. This often emerged during interviews when participants were telling of relationship stories or about their encounters with HIV using phrases such as, '*That sounds very familiar.*' I found myself making more use of these phrases during interviews where participants were hesitant to share negative relationship experiences and frustrations with their partner and I reflected afterwards that this was a mechanism, unconsciously deployed, to build rapport with participants. By bringing in my experience of similar, negative situations, this acknowledgement also functioned to reassure participants that I understood that relationships were not always a 'bed of roses' and welcomed them sharing their experiences.

On transcribing, I noticed how much ironic humour and laughter featured during the interviews, which I reflected was another way in which my participants and I signalled our shared social context and established rapport. In addition to my verbal signals during interviews, of my shared experiences, participants also

positioned me as an insider to their experiences, for example taking cues like the ring I wear on my left hand to remark '*You're a married man! You know what I mean.*' I did not refer to my HIV status in the documents introducing the research to participants, nor in my explanation of my background and interest in the subject, but for many participants the fact that I was interested in serodiscordant relationships, and was aware of concepts like TasP, was enough to position myself as a 'professional' relative to HIV. Some participants made this 'professional' position more personal and asked my status either before or after the interviews, but I noticed that no-one asked about my relationship status or my partner's HIV status. This observation further added to my analysis of the 'etiquette' of discussing the HIV status of others, even intimate partners (see Chapter 7, *Managing a serodiscordant identity*).

The fuzziness of the boundaries between insider/outsider became apparent when some participants assumed because of my interest in sexuality that I was also familiar with all sexual practices, relationship forms and the associated cultures: '*And obviously you're familiar with pup [play]...*' Perhaps related to the demographic similarity between me and the majority of my participants, feelings of being an outsider (other than when I adopted a 'professional' researcher role, outlined below) were rare. However, one instance brought out both the similarity of my experience with other participants with HIV and the stark contrast with others. In discussing previous experiences of HIV, many participants referred to hearing about it on the news or becoming aware through the 'tombstone' national awareness campaign. As these recollections were often vague or somewhat abstract, in order to probe for more concrete experiences, I had started asking a follow-up question about whether they had ever felt particularly close to or affected by the virus. For most participants, this elicited responses about their first HIV test or becoming aware that a friend or acquaintance was HIV positive. When I asked this question of Justin (76, HIV positive), I suddenly felt very naïve and insensitive for asking when he responded that having lost so

many friends, and his first long-term partner, due to AIDS in the 1980s it was something that he tried not to think about very much. The vast difference in our life experience became apparent and my personal view of myself as a careful and sensitive researcher was troubled by what felt like in the context an insensitive question.

During the research process I invested time and personal effort in positioning myself as a professional and competent researcher. In my early notes following interviews, I noted with angst points where I inadvertently asked closed questions or introduced laden terms such as 'normal' when asking spontaneous follow-up questions outside of the interview schedule I had created. Interviewing participants in their homes further added to my desire to be perceived as a competent and polite professional, being aware of the potential for power imbalance in the research process I researched and committed a checklist for researchers entering others' homes (Boyton 2016). Behaving in a formal, somewhat unusual manner when arriving at participants' homes brought out the strangeness of the research interview when viewed as a social event rather than a pure 'research encounter', the high levels of formality contrasting with detailed discussion of intimate subjects such as relationships, health and sex. As one participant responded to my text thanking them for the interview, *'It was odd. We enjoyed it. Nice to meet you.'*

Discussing sex, particularly with a focus on intimate details such as condom use, was another source of strangeness in interviews. Having read Einarsdottir's account of interviewing same-sex couples in their homes about sex (2012), I had prepared myself for potentially uncomfortable situations to arise that could challenge my position as a 'professional' researcher: potentially being perceived as having a prurient interest in sex, becoming embarrassed by unanticipated explicit responses to questions, or even how I would cope in the event I found my participants attractive or they viewed me as potentially sexually available. Unlike some of the participants Einarsdottir interviewed, my participants

appeared to position me as a non-sexual presence in their homes. I reflected that this might be explained by my experience as a community sexual health volunteer and experience of taking detailed sexual health histories before carrying out sexual health screening. For example, when asking direct questions about their sexual practices, I may have unconsciously adopted the clinical tone I had been trained to use during outreach. This 'professional' positioning was further exemplified during a couple interview, after discussing their open relationship and practices of inviting sexual partners to join them, euphemistically referring to them as 'visitors' one participant ironically acknowledged some similarities between the situation they described and the current 'three-way' interview, but swiftly clarified, *'But Tom is a respectable visitor.'* Based on the importance of 'cum' in some early interviews, I introduced specific questions into the interview schedule asking participants about where they or their partners ejaculated during sex with each other. Although during interviews this rarely caused significant embarrassment, discussing quotes relating to these data during supervisions or in conference presentations (particularly non-HIV specific meetings) the explicit language used by participants regained its power to shock or embarrass outside the 'safe space' of the interview.

One situation where my 'professional' researcher position was challenged in a different way was in the experience of interviewing a participant with whom I was already friends. After careful consideration whether it would be possible to include this participant in accordance with the ethical guidelines I had committed to follow, I went ahead with the interview. As Taylor (2011) has described in her experience of being an insider researcher with friends, as we were both already familiar with each other's relationship status and background, which made some aspects of the interview easier to conduct. Other details, such as negative relationship experiences and sex outside the relationship were more challenging for me to ask about and for the participant to discuss, because of concern about

what impact that this new information might have on our pre-existing relationship. I reflected that in this interview more than in others, I actively brought examples of my own experience into the discussion, as a way of both reassuring him I had similar experiences (as described above) but also balancing his disclosures with my own. Managing the different interview dynamic in this way altered my researcher role and emphasised more mutual exchange of information, more associated with friendships (Taylor, 2011).

Reflexivity extended beyond the data generation stage too. Within both hermeneutic phenomenology and thematic analysis, reflexivity plays an integral role in the process of analysis, with particular emphasis on 'bracketing' our own experiences (Finlay, 2011; Van Manen, 2016)(Van Manen 2016; Braun and Clarke 2019). When familiarizing myself with the data and trying to make sense of it, I found it particularly difficult to extricate my own experiences from the data: participants' own questioning of their relationships brought to the fore troubles I had experienced myself and re-reading transcripts of interviews that had taken place around personally difficult times brought those difficulties back to mind. Finlay suggests that by making ourselves a participant in our own research, we make ourselves more transparent and are able to bring out prejudices that could otherwise dominate research findings (Finlay and Gough 2003). However, making myself an object of analysis and turning to my own response to the data and research processes became distressing as I dwelt on parts of interviews which had strong emotional resonances for me. This led to difficulties in completing the analysis as, rather than examining my relationship to the data I elided into examination of myself and my relationships. This prolonged the process and made it difficult to comfortably spend the time that the different steps of analysis require (see *Analysis*). After recognizing that I had slipped into 'wallowing' in my subjectivity (Finlay, 1998) and that the personal distress that the research was provoking merited its own attention, I invested time in separate, personal reflection which helped me to both recognize my personal

and emotional relationship to the data and, in achieving this recognition, to put these to one side. Through this process of reflection, I was able to see how some early themes focusing on relationship 'trajectories' and 'purpose of relationships' were foregrounded by my own position and made me question more closely their bearing on the research questions I had identified for this project.

Finally, in preparing an article on the experience of conducting research on a sensitive subject (see Appendix G) I also drew on reflexivity to examine the way in which sensitivity emerged during the research process and how I reacted to and managed it during participant recruitment and data generation. This led to me recognizing the way in which an early encounter with a potential participant who was critical of the idea of the research influenced my interpretation of a slow response to my initial recruitment call. It also highlighted the way in which I proactively mobilized optimistic discourses from TasP and U=U as a way of countering the idea that making serodiscordancy the object of research was intrinsically stigmatising. This process of reflection also highlighted further rhetorical positions that I adopted during interviews to construct myself as someone who already 'knew' that serodiscordancy was 'normal' but who was obliged (in various ways) to ask about it anyway.

[Interviewer] Erm, and so we've talked about a few, kind of, factors that influence your relationship, or make it what it is. I kind of have to ask, what role does HIV play in your relationship, if anything?

Individual interview 14-01 (Witney, in press)

Reflecting on the unexpected way in which sensitivity about the research emerged in relation the 'normality' of serodiscordant relationships led to questions of normality and stigma taking a more central role in my interpretation of the data.

Summary

In this chapter, I have discussed how my initial interest in the topic drew me to phenomenology, particularly the focus on experience and use of interpretation to go beyond the everyday. I have outlined how these principles guided my data generation and how I approached my analysis. I have also set out the background of hermeneutic phenomenology and discussed how I diverged from Van Manen's definition of a fully phenomenological account of serodiscordant relationships, instead drawing on Braun and Clarke's reflexive thematic analysis to develop a phenomenologically informed thematic analysis. I have also outlined some of the challenges I experienced in recruiting for this study and how, although I initially aimed to recruit a diverse sample with representation across 'eras' of HIV epidemic, focused on urban centres with high prevalence of HIV, my final sample was relatively homogenous in terms of geography, age, ethnicity and class.

The role of 'recipes' for conducting analysis remains controversial, with Van Manen in particular arguing that any attempt to codify a phenomenological analysis risks fetishizing process over the product (2016). However, both he and Braun and Clarke agree that the mark of good quality analysis is not how faithfully the analyst has followed a particular method, but in adherence to principles such as rigorousness and trustworthiness and ultimately in the robustness of the product of the process. Accordingly, I have offered a detailed account of how I undertook a phenomenologically informed thematic analysis in order to provide insight into how I applied the heuristics provided by Van Manen (1990, 2016) and the framework for thematic analysis provided by Braun and Clarke (Braun and Clarke, 2006, 2019; Braun *et al.*, 2019). In line with good practice in both phenomenological and thematic methods, throughout the research process, I maintained a commitment to reflexive practice. I have discussed how this process clarified my own position in relation to the subject of the research and provided further insight into my role in the generation of the

data and its interpretation, as well as posing analytic and personal challenges.

5. 'Doing serodiscordancy' in the everyday: the work of undetectability

*'Yesterday, upon the stair,
I met a man who wasn't there!
He wasn't there again today,
Oh how I wish he'd go away!'*

Antigonish, William Hughes Mearns (1899)

One of the more striking findings I noted during interviews was how participants consistently responded that their serodiscordancy was not a defining factor of a relationship that they perceived to be normal. Assertions of normality are perhaps to be expected, as it is the reference point from which people make sense of themselves (Throsby, 2004). Yet while 'normality' is often taken for granted, sociologically it is a contested term, with multiple definitions and senses in which it has been explored and applied in different contexts (Misztal, 2015). In the context of marginalised or othered groups, assertions of normality can also be viewed as strategies to manage stigma (Goffman, 1963; Harris and Karimshah, 2019). Discourses of normality deployed by people in serodiscordant relationships have been examined and explored (Hughes, 2017). During analysis, however, I noticed how some participants went further to assert that HIV was largely absent from their day-to-day lives. Again, such responses are not unexpected in a study of everyday lived experience. Many aspects of our experience are so taken for granted that they seem invisible (Branaman, 2001, p. 11), hence the need for special modes of reflection in order to bring these elements out (Van Manen, 2016). However, absence can be more profound than simply things that are overlooked. Scott (2018) notes that absences can occur in relation to things that were once there, but have now gone and those things that

could have been but have never existed. For example, the absence associated with childlessness could result from miscarriage or infertility. Although these two types of absence are experienced differently (Lovell, 1983), in both cases these 'absent presences' (Shilling, 2012) can be perceived, remembered or imagined and, and are socially productive (Scott, 2018). HIV treatment acts at a molecular level to disrupt the replication of viral particles, resulting in levels of the virus being so low that its genetic material cannot be detected in the blood by biomedical tests. An 'undetectable' viral load is the foundation of the scientific principle of TasP, as without sufficient viral particles present in body fluids, transmission cannot take place. As I discussed in Chapter 2, the principle of TasP and its application as an epidemiological concept has become applied to individuals and their relationships. Through these processes of biomedicalisation (Clarke *et al.*, 2003) and the discourse of U=U, the undetectability of the viral genetic material in blood becomes, through its effects on transmission, a social transformation, productive of new identities of 'undetectability' and discourses that project these microscale transformations into the negation of social and emotional processes. As noted in Chapter 3, the 'absent presence' of an undetectable viral load has made available new social identities and approaches to risk management (Race, 2001; Guzman *et al.*, 2006; Prestage *et al.*, 2009; Kalichman *et al.*, 2013; Grace *et al.*, 2015; Cormier McSwiggin, 2017; Girard *et al.*, 2019). In addition, the absence of transmission risk afforded by biomedical prevention modalities has been associated with changes in affect in gay and bisexual men, most notably reductions in anxiety in HIV negative men taking PrEP (Whitfield *et al.*, 2019), gay and bisexual men participating in chemsex (Souleymanov *et al.*, 2019) and in serodiscordant relationships (Philpot *et al.*, 2018). Yet research to date has not considered how these absences are perceived and managed in the everyday context of relationships, which will be the focus of this chapter.

I will begin by exploring how participants drew on TasP to articulate their experiences of the absence of HIV in their relationships. I will consider how they made biomedical 'absence' of HIV at a molecular level meaningful in the context of their everyday intimacy. In the second section, I will examine the way in which participants' experiences of the absence of HIV were underpinned by biomedical practices. I will argue that in the context of serodiscordancy, these became 'practices of intimacy' (Jamieson, 2011), that is ways in which participants could express their closeness or specialness to each other. Through these practices, participants also created a sense in which HIV was made part of their relationship around which they could create a sense of safety and satisfaction in their own terms. This echoes Giddens's formulation of a pure relationship (1993) in which external referents are put to one side in favour of a focus on each partner's satisfaction. In the final section, I will consider how participants' experiences are inconsistent with the pure relationship thesis and were in fact inflected by stigmatising social norms of HIV. I will examine how these intrusions from the public sphere threatened to make HIV visible and how, participants worked to counteract this at the intimate level. In particular, I will use Hochschild's concept of 'emotion work' (1979) to explore participant's affective exchanges as they navigated between their everyday experience of HIV's unimportance and social norms that continue to pathologize it. I will argue that the absence of HIV perceived by participants is more than a consequence of biomedical processes operating at the molecular level but is created and sustained through daily intimate practices and participants' emotional engagement with serodiscordancy and their relationship.

'It's like it's not there' – the everyday absence of HIV

This section focuses on how participants drew on biomedical discourses of undetectability and TasP in order to articulate their sense of HIV being absent. It will argue that the in describing HIV having in some senses 'gone away'

participants were not suggesting that HIV had no impact at all, but that their experience defied social norms of HIV as a devastating condition. For example, William discussed how his diagnosis had a significant impact on his mental health and relationship with sex. These effects resulted in him seeking counselling, joining support groups and transforming his attitude to himself and his relationships. Although its impact on his daily life was made invisible by the medication he took, the role that it played in his biography was undeniable.

When I say when [HIV] means nothing, it means nothing because it's managed by medication. In terms of who I am as an individual, it has little to no impact on me day to day. But, on the flip-side, it has had a huge impact on me, you know, without my diagnosis, I wouldn't be where I am today

William (32, HIV positive)

This speaks to the temporality that underlies the absence that William describes. Five years after the 'biographical disruption' (Bury, 1982) of his diagnosis, he had incorporated HIV into his personal and work life as part of a renewed engagement with life (Carricaburu and Pierret, 1995). Yet despite the formative role that HIV had played, he felt that in his current, reconfigured life it played no additional part. Crucially, he attributed this lack of impact to the treatment that he took. Robert described his experience of HIV as an absent presence in his relationship. Although it was there, it was almost as a superfluous detail as it affected on neither his partner's nor his relationship's health.

I thank my lucky stars that I can be in a perfectly healthy relationship with someone who's perfectly healthy but who happens to have HIV

Robert (43, HIV negative)

Robert's gratitude for the absence he describes emphasises it as a socially and affectively productive phenomenon. However, his thankfulness also invokes the idea that HIV could have a detrimental impact. I will return to the emotionality of serodiscordancy in *The emotion work of serodiscordancy*, below.

Ben, who has been living with the virus since 1993 also described how the influence of HIV on his life and his relationship has been transformed, with it playing less of a role.

*It's almost like it isn't there in the way it was. It is there. But isn't half
as impacting*

Ben (48, HIV positive)

The change in the quality of the presence of the virus that Ben describes, of it having less influence emphasises the transformation of experience that treatment has wrought. In describing it as being present but less influential, Ben points to the way in which the diminution of its influence is experienced as a whole, rather than isolated changes in specific areas, such as his health or his relationship.

Yet even without direct experience of the impact that HIV can have, participants described their experiences of serodiscordancy as involving a change in HIV's impact. Matt's partner was diagnosed in 2012 and started treatment before they began their relationship. Yet Matt also describes HIV as being transformed and having an attenuated presence in daily life.

*HIV is there but in another level. It's like, what perfume are you using
today? It's another thing in your everyday life*

Matt (45, HIV negative)

Matt describes his experience of serodiscordancy as HIV having become an incidental feature of life: noticeable but as unimportant as the scent someone chose to wear that day. Justin, who had been living with the virus since the early 1990s, described how although he and his partner talked about his health and the issues that he faced, HIV was not part of the picture.

*We don't talk about it. We talk about other reasons for me not being
well or becoming unwell, but HIV doesn't... we both know that's not
likely to be a problem*

Justin and his partner's understanding of HIV as irrelevant to his current health issues underlies their lack of discussion. Rather than the purposeful silence and active avoidance of HIV that has been described in serodiscordant relationships before TasP (Persson, 2008), HIV has become of so little import that it needs no discussion.

This is further supported by Laurence's experience of serodiscordancy; although he still fears the virus, and the prospect of becoming positive himself, the absence of the threat of the virus from his partner allows him to feel a sense of safety and security within the relationship, even to the extent that he does not register the virus's presence.

So... to say I'm still scared or fearful of it. I suppose it is true. Not actually, not in the sense of daily, you know, I think to myself, oh I'm going to catch [it]. Actually, ironically, I feel extremely safe and secure with [partner]. Erm. And I actually genuinely now most of the time even forget that he's positive

Laurence (37, HIV negative)

The 'genuine forgetting' that Laurence describes is another way in which absence is experienced in the era of TasP. In contrast to HIV as an actively unacknowledged presence (Persson, 2008), HIV in Laurence's relationship can be safely forgotten and ignored. For other participants, although HIV itself could not be ignored, the absence of transmission risk was a positive and welcomed presence. For Patrick's partner, the absence of risk ameliorated the burden he felt of being a risk to others.

Well it means a lot to him as well. It's like you have this... what could be a bad thing, but you've done something about it and you're not [a risk], he's not in any way a risk to anyone. So I think that's

important. That's really important

Patrick (43, HIV negative)

As well as shaping the experiences of participants, the absences described here also had implications for participants' sexual practices. For Matt, his understanding of the PARTNER study results granted him a prize: sex without condoms.

It was like winning the lottery, now we can fuck without condoms

and without the HIV thing

Matt (45, HIV negative)

The absence of HIV allowed for Matt and his partner to dispense with the condoms that they had previously used to protect against transmission. I will further explore how participants navigated serodiscordant sexuality in Chapter 6.

For some participants, the absence of HIV in the everyday meant that it only rose to prominence when it featured in media or in culture. Robert occasionally became moved by stories about HIV in television programmes or at the theatre. At these times, his thoughts went to his partner and his experience of living with the virus.

The only times I get upset, but he doesn't know, is sometimes when we're watching TV and there's an HIV story or something. And I have said to him, when we were at... it wasn't Angels in America, but it was something like that... and afterwards I said, [I] just want you to know that if we are at something that is talking about it, there is a big part of me that just wants to hold your hand. And I want you to know that it does register, but I don't want to make it a big deal for you

Robert (41, HIV negative)

The absence of HIV in Robert's day-to-day life and in his relationship is reversed

when confronted with cultural stories of the virus. In these moments, the spectre of HIV loomed large and Robert became acutely aware of HIV and imagined what his partner's experiences of the virus - of diagnosis, of daily treatment, of the implications of it for his health - but also faced a dilemma in not wanting to draw attention to how he was feeling and bring HIV to the forefront of his partner's experience as well. He concealed his upset and refrained from reaching out to comfort (and receive comfort from) his partner in order to manage and maintain the absence of HIV from their everyday experience. The 'looming' of an absent virus is something that I return to in the next chapter (see Chapter 6, *Spectres of HIV*).

'It's just taking the pills' – everyday biomedical practices

This section discusses what role participants' practices relating to HIV treatment played in their experiences of serodiscordancy and how they incorporated them into their relationship intimacy. Participants drew strongly on the current biomedical discourses of the normality of HIV (see Chapter 2), based on the efficacy of treatment transforming it into a chronic condition. This idea was so familiar that some construed HIV 'no longer being a death sentence' as a cliché. All positive participants were engaged with medical care, regularly taking their treatment and were sustaining an undetectable viral load. This section examines how the practice of taking treatment was used by participants as a way of framing serodiscordancy as normal and how viewing HIV treatment as a practice provided opportunities to incorporate serodiscordancy into shared relationship practices.

In the biomedical context of well-controlled HIV, for most participants, the experience of being in a serodiscordant relationship was that of one partner 'just taking the pills.' Nick described how his partner's practice of taking medication was the only signification of HIV in their relationship.

Nowadays when you're on meds, you're undetectable, like, you can live a normal life. It doesn't have to be the be-all and end-all of things. If you take... he takes his pills in the morning, or he takes his pills when he needs to... and that's that

Nick (32, HIV negative)

Nick's mobilisation of a 'normal life' does not explicitly draw the link between treatment and TasP, but his suggestion that the presence of HIV is limited to taking treatment implies a freedom from concern both about his partner's health and about transmission. Charles also described a scene of normality but focused specifically on how treatment, through TasP, 'easily' made their serodiscordancy stable. Although it could not change his status, it could preserve his partner's negative status.

I think I'm normal and I think he's normal. And, so far as I can tell there's... I can't change my status. But we can do something about [partner]. So. We can keep him negative. But in this world where I just have to keep taking medicines, that seems pretty easy

Charles (41, HIV positive)

As well as enabling him to think of himself as 'normal' as his partner, Charles views his medicine as also enabling him and his partner to jointly 'keep him negative.' I will discuss the way in which TasP blurs boundaries of responsibility around HIV transmission (see Chapter 6) but here I would like to draw out Charles's emphasis on the simplicity of how this is achieved, by 'just taking the pills.' The view of treatment being an uncomplicated, even minor detail of participants' relationships was a common one. Muhammad (30, HIV positive) framed his daily regimen of three pills as a '*mild inconvenience*.' Patrick (43, HIV negative) compared his partner's treatment to domestic chores: '*a simple practicality*.' Acknowledging a tension between treatment as a simple practice and its important function in creating normality that I will discuss below, he also wondered whether this description made him '*sound too flippant*.'

Treatment reminders: Demonstrating care

A key element of the success of treatment is regularly taking it to maintain therapeutic levels of the drugs and ensure HIV cannot replicate. Participants universally understood the importance of adherence to the treatment regimen and all presented themselves or their partners as rigorous in regularly taking medication. For some HIV negative participants, although they discussed their partner's treatment earlier in their relationship, their partner's adherence was something that they trusted and took as read, as part of their partner's commitment to their own health. For other participants, treatment became a practice that they incorporated into their other regular relationship practices, part of the morning routine.

I just see him as... he's fit and healthy and he needs to take a tablet every day. And every now and again I need to... 'have you taken your tablet this morning?' 'Oh shit I haven't.' And I think it's just become so routine within our relationship... that for us it's a normal thing

Philip (51, HIV negative)

Regular reminders were a common practice that HIV negative participants adopted which allowed them to engage with their partner's treatment. Chris incorporated his reminders into a bedtime routine, based on the time that his partner usually took his treatment.

Most nights I probably say, 'have you had your meds?' And he doesn't get irritated by that at all. He has his alarm that goes off at 10:30 it's part of our [routine], you know, the chicken crowing in the house somewhere. And um, and I... usually always, I think, go in bed, 'have you had your meds?' And occasionally he hasn't and he remembers, but I think he would remember if I hadn't said it anyway, but you know

Chris (51, HIV negative)

Chris continues to check that his partner has taken his treatment, even though in most cases he already has. The persistence of this practice despite its lack of practical function speaks to it as a routine gesture of intimacy: in performing it Chris demonstrates his familiarity with his partner's medication schedule and his understanding of its importance. Yet he also recognises that his redundant reminders could become irritating - perhaps interpreted as a sign of a lack of trust in his partner's ability to perform a daily task. He also wonders whether, on the occasions that his reminder is effective, whether it was necessary or whether his partner would have remembered anyway. Although Chris presents his reminders as a potentially redundant and unnecessary intervention, another participant, Raul (34, HIV positive) suggests why Chris's partner may not find his interventions irritating: *'I mean, erm, he asks me if I've taken my pills, regularly, which doesn't bother me, it shows he cares.'* Similarly, Sean described how his motivation for reminding his partner about his treatment was motivated by concern for his partner's continuing health, rather than his own HIV status.

Not so much for worries about myself, more worries about [partner].

There's been a couple of days where he's been like, 'oh I've forgotten to take my meds again.' And that's not me thinking, 'oh my god I'm going to get it,' because it takes months to do that... but for him. It's more of that I want to [him] to be around for a really long time

Sean (36, HIV negative)

Here Sean constructs HIV as a more proximate and potent threat to his partner's health than to his negative HIV status. While he understands that an undetectable viral load takes time to deteriorate, Sean perceives any gap in treatment as a potential opportunity for the virus to interfere with his health and shorten his life, threatening their future together. Laurence also presents his regular reminders to his partner as rooted in empathy and care for him, reflecting on the time he had to take daily malaria prophylaxis and found remembering particularly challenging. However, he acknowledged that when he first learned

about his partner's positive status, they had a less altruistic bent and were to assess his adherence.

I check in with him, not every day, or every time, just now and again... I say 'have you taken your pills?' But I mean that it [in] more of an affectionate way... But I have to confess it probably used to be, 'I wonder if he's taken his pills'

Laurence (37, HIV negative)

As well as the meaning of reminders changing over time, the frequency of reminders by negative participants also changed. Several HIV positive participants discussed how their partners used to regularly check that they had taken their medication but had 'given up' after finding that their reminders were redundant. However, when established domestic routines became disrupted, as happened around holidays or work travel, negative partners once again took on a supportive role, checking that their partners had sufficient medication to last them for the duration of their trip. Incorporating the pattern of treatment into their relationships in this way provided negative participants with a way to participate in their partner's management of HIV and made it a shared activity. Activities performed at a certain time can take on the character of daily rituals and through them couples can deepen their familiarity with each other.

As well as providing regular reminders or support at particular times, other negative participants supported their partner's treatment practices by encouraging them to set alarms or bought divided pill boxes to make daily dosing simpler. Thom felt that although actually taking the pills was firmly his partner's responsibility, he could play a role in helping him to remember to complete the task.

I went shopping for pill boxes one day and we found the right one so he can just keep going and not lose it... it's not on me but I'm aware of it and I will, you know, play my part.

Thom (46, HIV negative)

In his awareness of his partner's treatment and 'playing his part', Thom's purchase of a pill box can be understood as an expression of care and support. Gabb and Fink (2015a) have argued that it is often through these routines and banal activities that couples express their togetherness and that they can be seen as opportunities to 'say, show and enact their love for each other.' Mitzel and colleagues (Mitzel et al., 2019) reported different patterns of treatment adherence between short- and long-term serodiscordant couples, highlighting the potential for changes in relationship dynamics over time to influence how TasP is practiced. Participants establishing routines and daily practices around treatment, as I have discussed here, supports the idea that relationship intimacy can support biomedical practices. The presence of these practices among newly established relationships complicates the picture painted by Mitzel's study and points to the complexity and messiness of processes of biomedicalisation and intimacy.

Although the practices discussed thus far have focused on ways of expressing closeness and caring, intimacy is not always associated with positive emotions. For Richard and his partner, who had an open relationship, Richard's diagnosis during their relationship symbolised the distance growing between them when they were already experiencing a 'rocky patch.' Richard's partner's lack of knowledge about what Richard's status meant and the details of his treatment provided an opportunity for Richard to draw attention to their lack of intimacy and express his disappointment with his partner during arguments.

I think I used it a little bit as a stick to beat him with. [...] I would turn around say things like, 'you don't remember what time I'm supposed to take my medication, whereas there's regular fuck buddies who know better than you do'

Richard (46, HIV positive)

By providing 'ammunition' during arguments, the role of understanding treatment as an intimate practice is further underlined - a lack of engagement

with treatment symbolises a deficit of caring. By contrasting his partner's understanding with that of a more casual 'fuck buddy' Richard defines (and demands) relationship intimacy through knowledge of his medication schedule.

This chapter has discussed how treatment, as a daily practice, played a role in serodiscordant relationships. Yet a tension remained around the place and importance of treatment in underpinning the sense of 'normality' in serodiscordancy. This tension around how much treatment can be 'taken for granted,' which is played out in an exchange between Alex (43, HIV negative) and his partner Vincent (30, HIV positive).

*(Alex) Every time he takes that pill, I'm so cognizant of how easy, and I don't mean easy, how easy it is in comparison to people ten years ago [...] I'm going to say, even after all this time, it does still register and I'm thankful on a daily basis that that's what he needs to do.
Yeah, I certainly don't take it for granted...*

(Vincent) ...So I probably do take it for granted. But then the reason that I probably do take it for granted is... I try not to think about it. Because otherwise I'd be thinking about it every day at 8 o'clock in the evening

(Alex) But I kind of think that's the right way for it to be [...] I don't want you to think about it

This exchange demonstrates the way in which HIV treatment occupies a contested position within a serodiscordant relationship. Through its simplicity it can be taken for granted; yet the very existence of the taken-for-granted normality which Alex and Vincent describe rests upon its continued efficacy. Alex engages in further emotion work around treatment: through the lens of normality, the treatment Vincent takes *should* be taken for granted. Yet by drawing on and contrasting their experience with historical experiences of HIV and expressing his gratitude, Alex emphasises the significance of treatment in this normalisation, imbuing treatment with importance beyond 'just taking' it.

Yet in his gratitude for the treatment that keeps his partner healthy, Alex brings forth an idea of what their relationship would be without treatment, or with the treatments of 10 years ago, one troubled with difficulty and ill health. By *'taking it for granted'* Vincent can hold at bay the possibility of ill health and mortality. As Alex and Vincent's exchange moves focus back and forth between the mundanity of the *practice* of taking treatment and the importance of the role which treatment plays, images of an alternative reality without treatment come into and out of focus. Similarly, Gary (40, HIV positive) also talked about how, although it was often a mindless task, sometimes the act of taking his medication made him reflect on his HIV status. This took on particular poignancy following the death of his father, prompting him to reflect on his decision not to tell his parents about his status. *'Some days you just do it without thinking and other days you just stop and think for a minute [...] I know my parents wouldn't be able to cope with [knowing about] it'* Seen through his father's eyes, HIV becomes *'denormalised'* and once again takes on troubled meanings. Despite its regularity and simplicity, the practice of taking daily pills could still evoke dormant images of HIV as a threat to health and wellbeing.

The realities of HIV biomedicalisation

Although many participants presented TasP as minimising the impact that HIV had on their relationship, others recognised the complications that were associated with the biomedicalisation of HIV. Shaun recognised the reality of a life with HIV as a chronic condition, describing a highly affected existence, involving commitment to regular medical supervision and a constant awareness of the impact of treatment on everyday life.

One of my friends who's positive put it this way: it's not a death sentence, any more, but be prepared to spend a lot more time waiting in doctor waiting rooms for tests in the first six months to a year, sitting around, having to go to things... he's like, it does

*change your life, you have to think about, 'oh I can't stay out tonight
because I've got to get home and get my meds,' like I haven't got
certain things on me. It's like a life-changing illness, it's like having...
it's more comparable to diabetes, you have to think about what
you're doing*

Shaun (36, HIV negative)

The life that Shaun describes, although consistent with the normalised discourse of HIV as a chronic condition, emphasises the day-to-day reality of engaging with biomedicine and, in doing so, makes visible the presence of HIV through its treatment and how - although attenuated - it can affect life beyond the clinic, changing the way his friend socialises and plans their life. The experience of daily treatment, and the impact of side-effects also motivated Ben, among others, to emphasise that although many aspects of HIV were mitigated by biomedicine, treatment itself presented potential challenges. In the face of a normalised picture of HIV, which he felt that some without direct experience might interpret as serostatus becoming irrelevant, Ben drew on his experience of the realities of treatment to moderate the idea of normality of life with HIV.

*And I think he [partner] maybe is one of the people who thinks, 'well
even if I do pick it up, it's a pill a day, it's not a big thing anymore.'
And I don't really encourage that or advocate that because, you
know, yes, it is easily treatable and a majority of people fare
perfectly OK on the treatment, but you know, if we can avoid it... it's
a good thing to avoid*

Ben (48, HIV positive)

In drawing on normalised biomedical discourses of HIV, participants countered stigmatising, pathologized accounts of HIV. The lived experience of positive and negative participants both supported and instantiated the normalised assertion that HIV is 'no longer a death sentence,' however this same experience of the day-to-day realities of biomedical management also provided instances which undermined the 'normality' of living with the virus. Some participants resisted

the interpretation of 'normal' as meaning that the experience of being HIV negative was no different to being HIV positive with the exception of taking a pill every day. While biomedical advances have in many ways made HIV invisible, participants emphasised the ways in which it made its presence felt, often through the biomedical itself. Hughes (2017) has described how serodiscordant couples in Brazil flexibly drew on discourses of normality to navigate the impact of biomedicine on their relationship. They also described life with HIV as normal, or 'near normal' because of treatment, but also simultaneously maintained through their discussion of HIV, the idea that living with the virus was still not itself a normal state. Although the impact of the biomedical has altered the way in which HIV is encountered in these participants' lives, it appears that the distinction between the serostatuses, and the differential value placed on them societally continues to be untroubled by these ideas.

Through this section I have argued that treatment is much more than '*just taking the pills.*' By reducing the lived experience of HIV to the experience of taking daily medication, the transformation wrought by the biomedical has provided the opportunity for HIV to be incorporated into the everyday. Although in one way treatment has made HIV less visible by suppressing viral replication and thus preventing the progression of disease and the emergence of symptoms, it simultaneously anchors an otherwise invisible virus firmly in the material. The daily practice of taking treatment provide an anchor for partners in serodiscordant relationships to create everyday practices around. Through their regularity and familiarity they become a part of life shared together (Gabb and Fink, 2015a). By entwining both prevention of symptoms and prevention of transmission, treatment becomes more than self-care and transforms into an expression of care for the health of the negative partner. It also provides opportunities to create a shared experience of HIV through relationship practices such as treatment reminders. These reminders are opportunities for negative partners to demonstrate practical caring but also hints at the potential for

intimate surveillance, monitoring the behaviour of their partner. Through its being woven into the everyday fabric of the relationship, HIV treatment becomes a core part of the experience of serodiscordant intimacy around which participants created a sense of normality and satisfaction in their own terms, echoing a 'pure relationship' (Giddens, 1993). I have also highlighted how in order to achieve this sense of normality, they engaged in emotion work in order to manage the mismatch between the simplicity of taking pills and the distress represented by the threat that HIV could still represent without them. Through these practices, participants are able to not only express their closeness and importance to each other but are working to continue to keep at bay the (absent) threat that HIV symbolises.

'It's not a big deal' – the emotion work of serodiscordancy

This section discusses the way in which participants engaged emotionally with the idea that, through the biomedically mediated absence of HIV, serodiscordancy was not a significant feature of their relationship. Although initial encounters with serodiscordancy were often portrayed as potential moments of disruption (see Chapter 7), many participants suggested that their current situation was characterized by a familiarity with and acceptance of the virus. Justin (76, HIV positive), who had been living with HIV for more than 30 years, felt that his status was an unremarkable feature of his 20-year relationship. The stability provided by treatment meant that his HIV had been incorporated into the everyday: *'It's part of your life. I really don't think about it much.'* This was echoed by Ray who had also been living with the virus for 20 years. He sought to incorporate HIV as part of his life alongside his family and his partner of 30 years. He achieved this by making HIV manageable through engaging with medical care and treatment.

It's been manageable. And I think that's what I wanted to achieve.

*So that I don't make a big deal out of anything, so it just becomes
part of the fabric. Which is what's happened*
Ray (61, HIV positive)

In this way, treatment made HIV a routine concern and part of the background of Ray's life. Ray's incorporation of HIV into his life allowed him to focus on other aspects of his life which, to him were more of a 'big deal,' such as his family overseas and caring for his older partner. The long periods that Justin and Ray had been living with the virus, and the length of their relationships provided time for adjustment and familiarity with their serodiscordancy to develop. Participants who had been diagnosed more recently or were in shorter duration relationships had also adjusted to their different statuses. Ed (42, HIV positive) described how, after being diagnosed during his relationship nine years earlier, he and his partner had both come to terms with the diagnosis, meaning it was no longer a source of tension between them: *'it's just like, you know, I'm OK with it. And [partner's] fine with it.'* Philip also experienced a fleeting moment of worry at the beginning of his relationship in 2010 but had quickly concluded that HIV was not important.

*In that very first weekend of our relationship, it was kind of, 'oh my
god this is a big deal'... to 'no it really isn't.' And from that point on
it really hasn't been a big deal*
Philip (51, HIV negative)

I consider the emotion work of disclosure (and being disclosed to) later (see Chapter 7), but here I focus on how Philip made this adjustment to the idea of his partner being HIV positive. He attributed it to his previous experience of supporting a friend who had been diagnosed years before. He credits becoming informed about *'the condition, how to manage it and all of those things'* as a key factor in his acceptance that HIV is not a 'big deal.' Past experience with HIV, through friends, family or professionally has been proposed as a key factor differentiating HIV negative gay and bisexual men who perceive HIV as 'distant'

from them and those who perceive themselves to have high proximity to the virus. These different outlooks have been associated with contrasting views of HIV and about people living with the virus and different approaches to managing HIV risk (Keogh, 2008b). Persson (2011) described how negative partners in heterosexual serodiscordant relationships also had a sense of 'normality' in their relationships, through which they were able to minimise the day-to-day influence of HIV on their lives.

In a different approach to arguing that HIV is 'not a big deal', Chris sought to outline the ordinariness of his relationship, portraying it as difficult, even troubled at times.

I hope I don't feel like I'm rescuing him or anything like that. I don't think so, I certainly don't treat him more gently or anything like that. He'd probably testify to that. And erm, I don't go easy on him or something like that. I mean I ended it twice so... I don't think 'oh poor [partner], I can't do this to him,' you know

Chris (51, HIV negative)

In presenting the turbulence of their relationship and his occasional lack of sympathy for his partner, Chris raises and then resists an image of people living with HIV as more fragile, or of deserving pity. In sharing that he has treated him harshly, Chris is asserting his partner's normality. Laurence also asserted his partner's normality in spite of HIV, teasing him that his HIV status did not make him 'special': 'he was like... I don't know why I've got a cold and I said, well you can get colds, you're allowed!' Though playful, his interjection undermines the idea that his partner's immune system is fundamentally different from anyone else's simply because of the presence of HIV.

In highlighting some of the tensions in his relationship, a lack of trust between him and his partner, Charles also navigates a course between serodiscordancy as a problem and not, between their relationship being troubled, or not.

With [partner], so he knew from the start. That I was HIV positive.

And bless him, it's never... been an issue for him. Maybe unconsciously, maybe. I don't know... if there's any... if that could be the cause of any of these mistrusts that we seem to be plagued with.

But, from what I know of [partner], HIV is not the reason

Charles (41, HIV positive)

Although he leaves open the possibility that his HIV status is the root cause of these problems, Charles dismisses the idea that it is undermining their relationship, based on his deep understanding of his partner's motivations. He stresses his view that these troubles are not directly related to a difference in HIV status, 'bless him' suggesting that he is grateful for his partner's acceptance of his status. The gratitude that Charles expresses was echoed by other HIV positive participants talking about their partners for whom HIV was 'not an issue'. This emotional labour (Hochschild, 1979) that these participants perform may not be directly related to their partner's attitude itself but reflects wider societal attitudes towards the HIV status and the greater value of being HIV negative. As well as disrupting the sense in which the relationship is judged in its own terms, this social discourse introduces an asymmetry between partners that further highlights the limitations of the 'pure relationship' (Giddens, 1993) as lens through which to understand serodiscordancy.

This asymmetry in serodiscordant relationships has been described in pre-TasP studies (Cusick and Rhodes, 2000; Rhodes and Cusick, 2000; Davis and Flowers, 2011) where sex without condoms was often construed as a 'gift' from negative partners to their positive partners, as an investment in the intimacy and security of the relationship, whereas it was the cause of anxiety and guilt among HIV positive partners. It also echoes the 'affective economy' described by Gabb and Fink (2015a) in a study of long-term relationships: small gestures, for example performing housework, from one partner could take on the status of gifts. That this asymmetry persists in relationships where the risk of transmission has been

widely understood by participants to have been removed through treatment points to both the uneven penetration of the biomedical into the affective practices and the way in which intimate relationships, rather than 'pure' operating in and of their own terms, are expressions of the social context in which they are situated.

Although the idea that HIV was manageable and therefore 'not a big deal' was dominant in most participants' discussion of the role that HIV played in their relationship, the psychological burden of being HIV positive was recognised by some negative participants who observed, or projected detrimental effects on their partners. Laurence (37, HIV negative) wondered how much his partner's status occupied his thinking, imagining that - even though it was not a daily topic of conversation - it was never far from his thoughts, '*does it not play on his mind, each day?*' Thom (46, HIV negative) recognised that his partner found his status to be distressing at times. He approached the management of the emotions related to his partner's HIV status with a strategy of minimisation, avoiding keeping the focus on negativity by ignoring or only discussing HIV when absolutely necessary.

It makes him sad. I know that it upsets him, but I try not to dwell on it. And, you know, we talk about it when it's... you know... valid

Thom (46, HIV negative)

The use of silence to avoid potentially painful topics relating to HIV and to spare positive partners' distress has been described in other serodiscordant relationships, with 'sero-silence' an important element of couples' strategies to create a sense of normality (Persson, 2008, 2011). Terry (33, HIV positive) also engaged in selective silence around HIV in his relationship, managing how he expressed his concerns about HIV with his partner. He felt it important not to talk negatively about HIV with his partner as he was concerned that he had developed the impression that Terry found his status upsetting because of how he reacted when they initially talked about it.

There are some things you cannot really tell your partner, because you know they will get worried [...] Maybe it's because when I told him the first time, I was crying. So since then he's worried that I worry about [HIV]. I really wanted to stop that. So I started not talking much about HIV, my own HIV, with him

Terry (33, HIV positive)

The complexity of this emotion work - Terry anticipated how his partner perceived his own feelings and managed their expression accordingly - illustrates the intricate construction of a sense of normality around HIV - and it not being 'a big deal' in their relationship. However, this was not the case for all participants, some of whom described a silence around HIV in their relationship that was less actively maintained. Nick emphasized how HIV was not something that he and his partner needed to discuss.

Like, it's not part of the conversation really because it's not an issue. Like way back when we first started, it was a bit of an issue because I was uninformed and ignorant. But now... we 'on't mention [it]... it's not like a spectre hanging in the corner of the room. It's not an issue, it's a non-issue

Nick, 32, HIV negative

However, part of its insignificance rested on the contrast between its potentially disrupting role early on compared with their current situation. Nick described becoming 'informed' about HIV as a key factor in his acceptance of its presence. Anticipating and rejecting the 'sero-silence' (Persson, 2008) some serodiscordant couples deployed, Nick stresses that the lack of discussion he and his partner have about HIV is more than an uneasy silence, a lurking problem unspoken, but a problem solved; a spectre exorcised. The state of normality that Nick and his partner have reached depended on more than him overcoming his former 'ignorance' about HIV and TasP. Crucially the peace he describes rests on his overcoming feelings of fear and distrust that he described in other parts of his interview as part of this 'education'. Participants' association of fear,

ignorance and HIV stigma and its resolution through education is explored further in Chapter 7.

On occasion, normalizing discourses had the potential to obscure negative emotions associated with living with HIV. Following his diagnosis, Tom engaged with advocacy and appeared in local newspapers and on television giving interviews about the changed world of HIV in the era of TasP. By projecting an image of HIV as normal and untroubling, he held back the distress that he experienced. Although his partner questioned the normalised image of HIV that he presented, he took his assertions at face value.

A friend of mine asked me, 'oh you know you seemed really on top of everything when you were diagnosed, but I always get the sense that you weren't being completely honest about that and there was something underneath it'. I told [partner] that my friend had asked me this... and it was really interesting. [He said] 'I think I just assumed that as well but never really asked.' Because I've put up this front almost of... 'oh yeah, having HIV is great, everything is fine, don't worry about it' and that was all the publicity, public stuff I did.

No-one really thought to ask, like, are you OK?

Tom, 26, HIV positive

Tom's partner's response echoes other negative participants, who managed feelings of guilt relating to how they first responded to their partners status (see *Emotion work of being disclosed to*). In this context, his partner may have avoided questioning whether he was really was untroubled to avoid being stigmatising. Further to this, questioning whether your partner is telling you the truth undermines a sociocultural belief in transparency and disclosure as key to relationship success. Thus both normalised discourses of HIV and norms of disclosing intimacy underpin the emotion work of 'doing serodiscordancy' in this situation: maintaining a commitment to normalised HIV discourse led both Tom and his partner to manage their emotions and to limit practices of disclosing

intimacy.

HIV negative participants also presented serodiscordancy as 'not a big deal' by arguing that they were untroubled by the eventuality that they might seroconvert. When they decided to stop using condoms, Nick (32, HIV negative) reassured his partner that even if he did seroconvert, it would not affect their relationship: *'I was like, you know, I love you. If the worst happened or if I did become HIV positive, that's not going to change my feelings about you.'* This affective exchange, even while disavowing the potential for HIV transmission to disrupt Nick and his partner's intimacy, rests on the assumption that his partner would bear responsibility for transmission and, furthermore, that Nick would be justified in asserting this. Davis and Flowers (2011) described a similar landscape in their study, in which negative partners potentially 'giving up' their negative status was treated as a demonstration of their love and commitment. In Davis and Flowers's study these gestures remained 'gifts' and could be withdrawn, as sometimes happened during arguments, where positive partners could be accused of 'threatening' their partner's health. Although no participants reported HIV being raised as a threat in interviews Nick and his partner's exchange above still rests on the asymmetry of responsibility for transmission. Embedded in a society in which an HIV negative status is positioned as normative, participants employed emotional labour in order to 'level the playing field.'

Considering the prospect of his partner becoming positive, Raul drew on his understanding of TasP to frame it as an unlikely, almost unimaginable event. Despite TasP, he still felt the potential burden of responsibility.

I really don't know how I would react. I would be very supportive, of course. I just hope it doesn't come from me. I don't see how that could happen. If anything, science would make us, even less and less likely to... to be able to do that

Raul (34, HIV positive)

The sentiment *'I just hope it doesn't come from me. I don't see how that could happen'* was echoed by many other HIV positive participants imagining their partner's seroconversion. Despite TasP making it a remote possibility, imagined responsibility for seroconversion was still associated with significant negative emotions. These scenarios imagined by participants in this study differ from those described by Persson (2013b; 2016) who found HIV positive participants had difficulty adjusting their self-image to incorporate the potential for treatment to render them uninfected. In one case this was due to a participant believing that she had an undetectable viral load when she did not, resulting in her partner's seroconversion. This event was so distressing that she could not imagine ever having sex without condoms again, despite reassurances provided by scientific data and viral load tests. Others had an enduring self-conception of embodied infectiousness that persisted despite an understanding of the concept of TasP. Persson highlights a group, often characterised by those in relationships formed during the recent biomedical prevention era, who embraced the concept of TasP and used it as an opportunity to reimagine and reframe serodiscordant intimacy independent of conceptions of risk. While this undoubtedly describes Raul and his partner's experience, I would argue that while TasP has transformed the biomedical risk landscape, the affective and moral landscapes associated with seroconversion and viral risk had not radically changed.

This section has considered the emotion work that participants engaged in to support the idea that HIV 'did not matter'. I have argued that this element of 'doing serodiscordancy' reveals how participants' emotion work engaged with and compensated for discourses of HIV as stigmatized and troubling. This analysis has shown how, through these emotional practices, participants had worked to make HIV 'not a big deal' in their relationship in the face of sociocultural values which continue to present HIV as troubling to relationships. Participants' experiences of serodiscordancy as normal and untroubled were underpinned by their understanding of the transformation of transmission risk

wrought by TasP.

Summary

This chapter has explored the ways in which participants engaged with TasP in the everyday; in particular, it has focused on the way in which they presented the impact of TasP as an absence of HIV. Their framing it as an incidental, or even trivial, feature of their relationship that could be ignored or forgotten contrasts with the way in which serodiscordant partners pre-TasP worked to make HIV absent as a way to lessen its impact on their relationship (Persson, 2008). Participants who had been in relationships before TasP contrasted their past and current experiences and described HIV as somehow 'gone away'. Yet, drawing on their previous understandings of HIV, participants who had no direct experience of serodiscordancy before TasP also presented HIV as somehow attenuated. The psychological benefits of TasP and the gratitude that participants reported echoes the benefits reported by other studies of the impact of biomedical prevention (Philpot *et al.*, 2018; Whitfield *et al.*, 2019).

In the UK biomedical context, in which all people diagnosed with HIV receive antiretroviral therapy regardless of CD4 or viral load has transformed (and homogenised) the experience of living with diagnosed HIV. The decision to treat everyone and the use of treatments without significant toxicities has had the effect of making the daily treatment itself one of the most salient aspects of being in a serodiscordant relationship in the UK. By on one hand rendering the effects of the virus effectively invisible and, on the other, requiring a daily practice of pill consumption, HIV treatment serves to incorporate the virus into the everyday. As I have discussed, daily treatment forms the basis of a series of everyday practices through which participants constructed the routines of their relationship. Incorporating these into the structure of their relationship enabled them to create a sense of security and satisfaction in their own terms (Giddens,

1993). In addition, I have argued that treatment provided an opportunity for positive participants to embody care for their partner. Negative participants adopted practices to support their partner's adherence, such as regular reminders or by buying pill cases, for example. Although many explicitly disavowed the interpretation of their participation in their partner's treatment in this way as surveillance, one participant, Laurence, described how initially his checking did carry at least some of this meaning for him. Viewing these as 'practices of intimacy' (Jamieson, 2011) shows how in the everyday, TasP provides further ways for partners to express their closeness to each other and embody caring.

I have also discussed participants' emotional engagement with TasP in the everyday and how they minimised the impact of their difference in statuses, framing it as 'not a big deal' and thus not a barrier to their mutual satisfaction with the relationship. However, deploying the lens of 'emotion work' reveals the influence of the unequal social capital afforded to people of positive and negative serostatuses. In parallel with Hochschild's (2012) illustration of a woman potentially owing her partner an emotional debt of gratitude for equal treatment in a societal context where women are generally deemed subservient to men, behaviours and attitudes that taken for granted in other relationships are deemed praiseworthy or even heroic in the context of a social view of HIV as an issue. Davis and Flowers (2011) found that social conceptualisations of HIV underwrote emotional dynamics in the gay serodiscordant relationships they examined. The difference in HIV status provided opportunities for negative partners to demonstrate their love and commitment, but this derived from an imbalance which invested a negative HIV status with greater power. The HIV negative partner remained in control and could wield this influence over the positive partner during disagreements. Cusick and Rhodes also described this imbalance in their study of heterosexual serodiscordant relationships, where positive partners could be blamed by their negative partners for putting them at

risk, even when they had initially consented to sex without condoms (Cusick and Rhodes, 2000). In some cases, this asymmetry has been exploited by abusive partners to undermine a positive partner's self-worth (Savage, 2017). Through this exploration of emotional dynamics I am not seeking to question the motives of participants or to suggest that their relationships are in any way troubled by their difference in status, instead through this analysis I point to the influence of enduring social, historical and memorial conceptions of HIV as troubling. I have argued that managing these normative views of HIV status as they reach into the intimate sphere involves participants engaging in emotion work in order to create and sustain an everyday context in which HIV is perceived to be absent.

Throughout the chapter, the primary focus has been on participants perception and presentation of HIV as absent. This absence has been of the kind described by Scott (2018) as relating to something that had been present, but is now gone. This absence highlights the temporality that underpins these experiences of serodiscordancy and emphasises their situatedness within a particular moment of time in the history of the epidemic. It also points to the way in which the experiences that participants describe and their emotional engagement with them are predicated on experiences of the presence and impact of HIV. The former presence of HIV haunts the absence that participants describe and continues to be an important reference point from which participants anchor their current understandings of serodiscordancy.

6. 'Doing serodiscordancy' in the bedroom: risk and (ir)responsibility

Eric Fuck me harder

Toby That feel good?

Eric That feels amazing. I love you, Toby

Toby Oh God, I'm close already. Shit, I'm sorry

Eric It's okay Toby. Cum inside me.

Yeah, Toby. Yeah.

God I love you

I love you

I love you

God, I wanna get married

Toby stops

Toby What?

Matthew Lopez, The Inheritance (2018)

As I outlined in Chapter 3, the subject of intimacy is inherently messy (Plummer, 2003) and processes of transformation of biomedicalisation are similarly untidy (Clarke *et al.*, 2003). Arguably, sex is the messiest topic of all. Sometimes literally as well as metaphorically (as the quote above illustrates). This can be seen in the number of urban myths about sexual intimacy in relationships that permeate society (Gabb, 2019). Sex is at the nexus of competing discourses; it is often conceived of as crucial to relationship success and is entangled with questions of romance and affection. As the quote above also shows, the act itself can be fraught with expectations of performance, performance that can be quickly disrupted by intrusions from other spheres. Although one of the stated aims of this research is to explore experiences of serodiscordancy away from sex and risk, to neglect the subject entirely would leave an incomplete picture.

This chapter details the way in which participants framed sex within the context of their serodiscordant relationships. In focusing on participants' sexual relationships, this analysis considers how participants understood HIV transmission risk in the context of TasP – this includes detailed discussion of their sexual practices, including condom use. This approach to studying sex owes much to earlier research which aimed to elucidate the details of gay and bisexual men's sexual practices, with particular attention paid to 'who did what and to whom' (Coxon, 1996; Phellas and Coxon, 2012) and also to studies of serodiscordant sexuality which placed risk management practices such as serosorting and seropositioning in their social context (Kippax *et al.*, 1993; Keogh, Weatherburn and Stephens, 1999; Flowers, Duncan and Frankis, 2000; Davis and Flowers, 2011; Bourne *et al.*, 2015). In addition, drawing on a literature of 'intimate practices' (Jamieson, 1998) and considering the 'relationship work' associated with sex (Gabb, 2019), it places serodiscordant sexuality in the context of participants' relationships. Inspired by its phenomenological foundation, it focuses on participants' experiences of sex and sexuality in order to examine how participants make meaning in relation to their sex lives. In doing so it will consider the political and ethical discourses participants draw on to contextualise their relationships and, using the theories of boundary work and biomedicalisation, examine some of the ways in which the biomedical transformations wrought at a molecular level by HAART translate into transformation in participants' experiences and how participants renegotiate notions of risk and responsibility associated with public health discourses of safer sex.

'There's more to it than sex' – Serodiscordant sex 'work'

This section deals with the emotion work participants engaged in relating to the role that sex played in their relationship in order to examine how, even though

not all participants currently had a sexual relationship with their partners, sexual intimacy is a key feature of 'doing serodiscordancy'. Sex is often positioned, both within popular discourse and some relationship literature, as the cornerstone of relationship success (Gabb, 2019). Despite this often being taken as a universal truth, supported by an understanding of sexual desire as a 'natural' part of human relating, through a sociological lens, private intimacies are socially shaped (Gagnon and Simon, 1974, 2003). Applying Hochschild's (1979, 2012) concept of emotion work to sexual intimacy further emphasises the way in which partners work to hold at bay the social hierarchies and socio-cultural mores that impinge on intimate relationships (Gabb, 2019). Through this work and other associated practices of intimacy, partners contextualise sexual intimacy (and its waxing and waning) as one thread in a tapestry of relationship intimacy.

Paradoxically, in serodiscordant relationships, the consideration of sexual intimacy as fundamental is further reinforced by their construction through a public health lens focused on transmission risk and its management. Sexual intimacy not only becomes a cornerstone of success but a defining feature of serodiscordancy itself. Many participants drew on narrowly defined ideas of serodiscordancy, conceiving of it primarily as a sexual phenomenon. This meant that Nathan (55, HIV negative), for example, questioned whether his non-sexual relationship would be a legitimate object of study and asked his partner to '*check whether or not it was important to you for the couple to still be having sexual relations because of the differences in status.*' Similarly Philip (51, HIV negative) located serodiscordancy firmly within the domain of the sexual, arguing that '*Outside the bedroom... it's just not an issue.*'

Limiting the influence of serodiscordancy to the sexual to some extent contained the threat that it posed and also provided a mechanism through which its influence on relationships could be managed. After Peter's diagnosis, he cut off sexual contact in order to isolate the threat of his partner's seroconversion.

I didn't want [partner] to even touch me. I was so petrified because he was tested, he's negative, still is negative. I didn't want him to come near me in case... just in case

Peter (58, HIV positive)

Thom also found that his partner's diagnosis led to a break in their sexual intimacy, although he situated the disruption within a longer pattern of a gradually waning sexual relationship.

It stopped our sex life, pretty much [...] for many years in our relationship we were fairly evenly matched, sex-drive wise. And then it just... [partner]'s just slowed down quicker than mine did

Thom (46, HIV negative)

The close relationship between 'dangerous' serodiscordancy and sex meant that avoiding sex was one way in which participants managed that threat. Yet, as outlined above, sex continues to be framed as an important contributor to relationship validity and satisfaction. Just as partners in long-term relationships see sexuality as one thread in a rich tapestry of relationship intimacy, participants who were not having sex portrayed their current lack of sexual intimacy in the context of the other forms of physical and emotional intimacy that they shared.

Yep, cuddles, a lot of stuff. OK, you know, we're not having sex, but there is... more to that side than the sexual act. And all of that is still relevant. Erm. You know it's companionship, it's friendship. It's... part of you, it's the other half

Nathan (55, HIV negative)

Nathan points to the fulfilment and sense of wholeness that his relationship provides, even without sex, echoing Giddens's identification of relationships as providing ontological security (Giddens, 1991). But while Richard emphasised the way in which sex was not the be-all and end-all of their relationship, he located serodiscordancy solely within the domain of sexual practices.

*We rarely have sex together now anyway. We're more of the
dodderly old couple that sort of, you know, shares stuff together and
go on holidays together and that kind of thing and cuddle up
together. But it's not a tempestuous sexual relationship. Therefore
his status and my status doesn't have any bearing*

Richard (46, HIV positive)

These participants appear to draw on a pre-TasP public-health informed understanding of serodiscordancy as primarily associated with sexual risk, with connotations of danger to the continuation of relationship. Through their positioning of serodiscordancy as primarily a consideration of sex and simultaneously emphasising the importance of other forms of intimacy for their relationship satisfaction, they are able to resist the notion that the stability or validity of their relationship is endangered by its serodiscordancy, without deploying the biomedical transformation of risk engendered by TasP. In this sense, these participants are articulating a version of the 'pure relationship' in which external considerations of relationship validity are rejected in favour of a focus inwards on partner satisfaction (Giddens, 1993). Participants focus on not just their own, but their partner's satisfaction with the relationship as the defining factor of its success. Further complicating this picture, these considerations are interwoven with the dynamics of waxing and waning of an individual's sexual desire that all couples navigate over the course of their relationship, as well as changes in sexual appetite that occur with age (Gabb, 2019). The intersection of relationship duration, age and serodiscordancy exert a complex influence on participants' sexual relationships, but these data show how they accept the dynamic shifts that have occurred over time as part of the vital nature of their partnership.

Participants whose relationships were sexually active also positioned sexual intimacy within a broader context of intimate relationship practices. For many,

although there was an expectation of regular, enjoyable sex being an important part of a successful relationship, they viewed their sometimes-troubled sexual intimacy as one element alongside other considerations that supported their relationship, such as physical intimacy, mutual attraction and fun.

I do still fancy him, even after 6 months in. And it's nice. Just to be intimate. Like he's very cuddly as well, so sometimes cuddles turn into sex. Yeah. It's still fun

David (39, HIV positive)

As with other gay couples in long-term relationships (Gabb, 2019), participants recognised and worked to manage discrepancies in sexual appetite, often using humour, balancing a transactional view of sexual intimacy with one bound up with emotions.

I think [partner] in this matter, he provides... a lot of energy. He's more active. And he's more willing to initiate. So, I appreciate that. Because... of course I want sex. But... I feel lazy too. [...] And in terms of that, I think he's really considerate. [...] So this morning when he took the initiative it was... like, OK I have to!

Terry (33, HIV positive)

Terry recognises an expectation for regular sex as a factor supporting the continuation of his relationship and values his partner's continued efforts, even if his 'laziness' sometimes gets in the way. Engaging with not only his sexual appetite but acknowledging it was important to satisfy his partner's, Terry engages with the idea that relationships take work to maintain and are founded on mutual satisfaction and give and take (Giddens, 1993). Although the men in this study drew less on gendered scripts of male sexual appetite many acknowledged frustration in the face of discrepant desire for sex and discussed how this introduced a power imbalance in the relationship.

I feel like [partner] holds the power in the sex in the relationship, I don't mean about top, bottom. I don't mean that, we're versatile in

that regard. I mean in terms of... he's the gatekeeper to when it happens. Not totally, sometimes when I suggest it he'll be up for it, but he can also say no. Whereas I'm most often up for it, if it's been 24 hours. But I've always had a high sex drive, so that doesn't surprise [me] in [a] way. Yeah. So I find that a bit difficult, a little bit difficult. I don't like not being gatekeeper

Cliff (51, HIV negative)

Cliff's frustrations were shared by Patrick (43, HIV negative) who began to feel that because his partner was not initiating sex as regularly as he was, *'it equates to the idea that you don't think they're all that into it. That they either allow it to happen or they don't and I think I was becoming more or increasingly frustrated by that.'* Both Cliff and Patrick viewed sex as a fundamental element of their relationship, without which their intimacy would be incomplete. Patrick wondered, if his partner was no longer interested in a sexual relationship with him, *'do we want to just consider ourselves more like housemates?'* A lack of interest in sex equated to a lack of interest in being in an intimate relationship. These interplays around sex and its negotiation – independent of serodiscordancy – reveal underlying power dynamics and the role of emotion work that many same-sex couples employ in navigating them (Heaphy and Einarsdottir, 2013; Umberson, Thomeer and Lodge, 2015; Gabb, 2019). The social normativity accorded to a negative HIV status has been shown to further complicate these dynamics in serodiscordant relationships, with positive partners having less power to determine the couple's sexual practice (Davis and Flowers, 2011; Persson, 2013b; Bourne, Owuor and Dodds, 2017). The difference in power between partners to determine sexual activity and an indication that this divides along serostatus lines provides an example of how the equality central to the idea of the 'pure relationship' breaks down in everyday contexts. Although participants subscribed to its ideals, as with gendered patterns of housework (Jamieson, 1999), this was belied by their practices.

In other contexts, participants portrayed themselves as willing to put off sexual

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intimacy temporarily while considerations like health intervened. Nick's partner had recently undergone treatment for cancer, which had made sex painful for him. While they continued to have an open relationship which meant that he could 'have people around' for sex, Nick emphasised the importance of love in their bond, which meant that sex with his partner could not be replaced by the sex that he was having with others. At the same time, the availability of sex with others also allowed Nick to continue to feel sexually fulfilled without imposing his desire for sex on his partner.

It was still a bit painful for him, so we... as a couple haven't had sex like for... a few months now. Because, you know, his health is more important [...] yes having people round is nice, but having sex with the man you love... you can't get any better than that. And so, we're kind of not taking a break from sex [entirely]... it's... we still do have the occasional person round. It's not so important right now because he's healing up. And I just, don't want him to feel like, I'm sitting here [waiting], 'when are you going to be ready, when are you going to get better?'

Nick (32, HIV negative)

Nick's practices in relation to sex include the emotional work of navigating his open relationship while ensuring that his partner feels supported during his recovery. Justin also discussed the emotional work he engaged in when navigating his loss of interest in sex, as well as the physical discomfort he was willing to put up with in order to fulfil what he saw as an important part of his relationship.

I seem to have lost all interest in sex. I rather hope that it's not permanent. Partly for [partner] because he obviously hasn't [lost interest]... But if we do [have sex], which he initiates, if we do occasionally have sex, I enjoy it. But it's all so... I mean apart from any intellectual thinking about wanting sex, it's also a bit of an effort. And I get breathless and a lot of movement's painful and I think

*that's all a bit off-putting. But yes [...] I would like to be able to make
more fun for [partner]*

Justin (76, HIV positive)

In navigating and negotiating a 'good enough' sex life through health concerns and as bodies aged these serodiscordant couples worked in a similar way to other long-term LGBT couples, working flexibly to find solutions which worked for them at a particular time and in their particular context, at times drawing on relationship openness or enduring discomfort in the context of an ongoing, loving relationship (Gabb, 2019). For these participants, serodiscordancy was not a significant consideration in the ongoing management of their sexual intimacy. However, as epidemiological data suggest that people living with HIV experience comorbidities and diseases of ageing at a higher rate and earlier than the HIV negative population (Sabin and Reiss, 2017), the impact of ageing and living with a long-term condition may lead to serodiscordancy having an indirect impact on sexual intimacy.

Returning to Peter's experience, as with other participants he makes sense of his relationship in multiple ways, drawing on concepts such as his partner's sexuality as a drive that demands satisfaction and the idea of an open relationship as a way to meet his partner's need.

And I remember thinking... but he probably has needs. And rather than losing him, because I can't meet those needs... liberating him. So I said to him, 'if you want to have physical relationship with other people, then do it. Be careful.' And there are certain [rules]... we eventually over a period of time established sort of house rules. Just to make sure that he's safe. I am safe. And that's how we've kept it.

And it works for us

Peter (58, HIV positive)

Peter invokes a model of masculine sexuality as an appetite that demands satisfaction, which he distinguishes from the physical and emotional intimacy

through which he and his partner sustain their relationship. Peter and his partner work together to establish their 'rules of engagement' for sex outside the relationship in a way that 'works' for them. They draw on the idea of the 'pure relationship' to set their own standards based on their mutual satisfaction, while simultaneously combining it with public health ideas that focus on the importance of their individual sexual safety. Though they do not have sex with each other, by deploying agreed practices outside their relationship, Peter and his partner 'do' sexual responsibility (Robinson, 2018), maintain a sense of sexual safety and are able to rely on their relationship to support a sense of ontological security (Giddens, 1993). In the next section, I will consider how other participants framed their sexual practices as 'responsible'.

'You don't need to use a condom' – Negotiating serodiscordant sexual practice

As the foundation of a public health programme of HIV prevention, condom use became enshrined as a hallmark of a 'healthy' gay sexuality (Keogh, 2008a). As I outlined in Chapter 3, condom use within the context of serodiscordant relationships was the focus of intense psychological and epidemiological study in order to understand factors which undermined their deployment (e.g., McLean *et al.*, 1994). At the time, gay men in serodiscordant relationships who did not use condoms portrayed condoms as a barrier to proper relationship intimacy and drew on discourses of love and commitment to the relationship and to each other to frame their decision making (Davis and Flowers, 2011). TasP, operating at a molecular level to ameliorate HIV transmission risk, troubles the role of condoms in serodiscordant relationships. Persson and colleagues (2016) found that serodiscordant couples responded to TasP as either interesting but ultimately theoretical information which would not change their use of condoms, as an endorsement of their current lack of or inconsistent condom use, or finally as 'permission to explore' sex without condoms. This section turns to the way in

which participants navigated the use of condoms in their sexual practices.

As with participants in other studies of serodiscordant relationships, many participants in this research used their understanding of TasP to stop using condoms (Persson *et al.*, 2016; Philpot *et al.*, 2018). Despite their trust in the concept of TasP, the decision to have condomless sex was one that still held significance. Matthew highlighted how, in the same way that regular treatment became part of everyday routine (see Chapter 5); not using condoms was something that became normal through repetition.

You think about [risk] to begin with. And I'd say you particularly think about it to begin with when you... if you choose to stop using protection. And then that kind of goes away. And everything just... it just all normalises

Matthew (30, HIV positive)

Matthew's experience of stopping using condoms with his partner as part of their normal relationship practices rests implicitly on his engagement with his treatment and the stability of his undetectable status. Philpot and colleagues (2018) also found that men in same-sex serodiscordant relationships who were relying on an undetectable viral load for the prevention of HIV transmission also built up a sense of normality through repeated episodes of condomless sex without transmission to the negative partner and the stability of regular test results. This underlines how the sense of normality participants have outlined here are predicated on the continued adherence to and efficacy of the antiretroviral regimens that the positive partners are taking.

One of the key elements of TasP is the concept that treatment alone is sufficient to prevent the transmission of HIV. In this context, the role of barrier methods, such as condoms, which had previously been the mainstay of prevention becomes uncertain. Many participants used their understanding of TasP as an opportunity to stop using condoms in their sexual relationships. For participants like Patrick, having anal sex without a condom and ejaculating inside his partner,

previously a taboo act, brought its own benefits.

*There's an element of... it kind brings on this element of deviancy...
the joy you have in sex when you're doing something that's a little
bit dirty or a little bit frowned upon or a little bit taboo*

Patrick (43, HIV negative)

As well as indulging in an act which carried connotations of deviancy, participants also reported preferring sex without condoms because it felt better and provided greater feelings of intimacy during sex. Ben (48, HIV positive) described how sex without using condoms felt to him like *'that sort of total feeling of, you know, well we're conjoined.'* For other participants, rather than the frisson of indulging in a previously frowned-upon act or to increase feelings of intimacy, not using condoms was understood as an act of faith in undetectability and in the transformation of HIV positive bodies from potential sources of transmission to being uninfectious. This had particularly important connotations for some HIV positive participants:

*I went to real efforts to persuade him that he didn't need to use a
condom with me. Erm. That was interesting. I think for me it was far
more about my status than it was to do with enjoying the sex more.
It was like... I wanted him to make me feel, like my status hadn't
changed anything. And not using a condom was one way to
demonstrate that. To demonstrate his lack of concern. Or his
knowledge that there was zero risk*

Tom (26, HIV positive)

For Tom, his partner not using a condom when they had sex was an important part of his new identity as an undetectable HIV positive man and to help him manage the self-stigma that he initially felt after his diagnosis. Drew and his partner started having sex without condoms while awaiting confirmation of his partner's viral load after a change of medication. They drew on their understanding of the stability of an undetectable viral load and knowledge that

other effective prevention options were available to frame their decision as informed and responsible risk management, while indulging his partner's desire for Drew to ejaculate inside him.

It was kind of something we'd talked about beforehand because he'd said that he really, really wanted me to cum inside him. So. It was kind of like, oh. OK [...] I think he'd also had the results saying that he was still undetectable. I think those results came after the first time that we had bareback sex. I think there was an aspect of, 'well I'll get them in the next few days, if I'm not you can go and get PEP [post-exposure prophylaxis].' If he wasn't undetectable

Drew (22, HIV negative)

Drew and his partner used their understanding of broader biomedical prevention methods, such as PEP, to support their decision not to use condoms. This planned use of PEP falls outside of medical protocols that frame it as an emergency measure and further highlights how the meanings of biomedical interventions are adapted by those that use them. As with previous innovative approaches to HIV prevention created outside biomedical contexts (Flowers, 2001), gay and bisexual men's engagement with biomedical prevention is productive of different ways of managing risk (Young et al., 2019). This illustrates how the processes of biomedicalisation, rather than being monolithic and complete are partial, situated when deployed in personal and intimate contexts (Clarke et al., 2003; Keogh, 2016; Young, Flowers and McDaid, 2016). Other participants' previous experiences and expectations shaped their current relationship experiences and how they navigated condom use after TasP. For Charles (41, HIV positive) and his partner, stopping using condoms shortly after their relationship began took on a different symbolism, embodying the monogamy that they had just agreed to embark on. Having used condoms in his previous relationships, Charles found it difficult - both practically and psychologically - to get rid of the supply of condoms he had distributed through his possessions. However, for Charles's partner, who had rarely used condoms in

his long-term relationships, they were associated with casual sex and were therefore symbols of potential infidelity.

For [partner], trust is really important. But instead of just getting rid of them all, I got rid of most of them [...] and we were living a week at mine and a week at his. And we both had travel bags. So it went down to just having two condoms in the travel bag... and then one. He said 'if there's no condom in the travel bag, do I assume you've had sex with someone else?'

Charles (41, HIV positive)

The presence (and then absence) of condoms in their shared space held potent symbolism for his partner, as a tacit admission of a breach of trust as well as a means of surveillance. The logic of 'negotiated safety' (Kippax et al., 1997) rests on monogamy in order for partners to dispense with other forms of risk management, but makes issues of trust paramount. Thus condoms become a symbol of mistrust: *'if we're monogamous, in a relationship, would I need condoms anymore?'* This focus on condoms as protection from risk posed by casual partners resonates strongly with public health discourse and illustrates its influence, even in a setting where they are not used and further positions condoms as tools to be deployed in situations of uncertain risk. In viewing their presence (and absence) with suspicion, Charles's partner demonstrates how questions of trust and fidelity often go hand-in-hand with questions of transmission risk in the intimate lives of gay and bisexual men.

The decision not to use condoms was often constructed as a joint decision. In response to his partner's concerns about transmitting the virus, Nick reframed the risk as one that was shared, rather than one that he faced alone. In invoking his love for his partner, including his HIV status, Nick placed HIV as part of their relationship, rather than something that threatened it.

It used to be a big deal, but now... I remember saying that to him when we first started to... decided that we weren't going to wear

condoms, I was like, 'I love you, HIV is just this tiny little insignificant part of you, but I love you.' Because the conversation came up 'What happens if you, if I transmit the disease to you?' I was like I wouldn't leave you, I'm taking the risk as well. There's two of us here, it's not just my decision, or just your decision, there's both of us

Nick (32, HIV negative)

Similar to Matthew's discussion of normality, Nick's discussion of how he and his partner came not to use condoms presents a journey from HIV and condom use starting as a significant factor, which becomes an accepted fact incorporated into everyday practices.

Some participants continued to use condoms in the sexual relationship they had with their partner. Despite new knowledge about TasP and its implications for their sexual activity, patterns established earlier in his relationship continued. Philip saw HIV as preventing him from stopping using condoms with his partner, as he had done in previous relationships. He portrayed condoms as a barrier to spontaneity in their sex life. In limiting the settings and times in which they could have sex, condoms (and therefore HIV) made sex less exciting and adventurous, as well as less risky.

It doesn't mean anything in terms of how I think of him or feel about him. But what it does mean is that I cannot be as spontaneous with him as I would want to be. If we're in a situation where, I just want to have sex with you right now... I can't. Not without taking risk and, all of that stuff. I don't carry around boxes of condoms and all the rest of it [...] whereas if he were negative, then, we could. If we were tested and that's what we'd agree that we'd do, we could be more spontaneous as to when and how we had sex

Philip (51, HIV negative)

Although he can imagine a more spontaneous sex life if his partner were

negative, this freedom to have sex without the need for condoms and the logistics of carrying them is still bound by biomedical surveillance and predicated on an explicit agreement with his partner about their not using condoms. While he can envisage some biomedically mediated situations in which condoms would become optional, his understanding of TasP as significantly reducing, but not excluding, risk places it outside of what is acceptable. For others, although they were aware of the implication of TasP that condoms were not necessary and could imagine not using them, they continued their previous habit of using them, even if there was no clear reason for them to do so.

And I thought, 'well we don't actually have to do this' [use condoms], but for some reason we still do. And I think actually it's more me than him

Ed (42, HIV positive)

Ed's lack of certainty as to why, or even who decided to continue condom use undermines the rational, openly discursive model that underpins much of public health discourse around condom use and its negotiation and speaks to a fuzzier picture of shared decision making without clear lines of argument, unclear individual influence and responsibility, and equivocation around decisions. Justin had discussed TasP with his partner of 20 years, but despite his suggestion that condoms were no longer necessary when they had sex, his partner continued to use them.

In the last few months I've said to him, 'you don't need to use a condom, you know.' But he did. He said he would. And I don't like to push it because... maybe that's started some thought going, I don't know

Justin (76, HIV positive)

Although he accepted his partner's decision to continue condom use, Justin foresees a potential future in which they do not use condoms and a path of

gentle persuasion along which his partner might travel. This image of a journey of encouragement, an argument to be made over time, a gradual change in decision-making processes stands in contrast to the dramatic conversions of U=U rhetoric. It also gently questions the assumption that not accepting U=U stigmatises people living with HIV; having long accepted the presence of HIV condom use as part of their sexual repertoire for many years, questions of fear of transmission or stigma have lost some of their relevance.

Other participants had a more complex relationship with condoms, using them in some situations but not others. Raul and his partner combined the strategies of TasP and seropositioning in their sexual practices.

I'm a sort of new top. I've always been a bottom. And I'm experimenting with him really. I'm not a full-on top, I don't know how to do it really. He's sort of guiding me. So whenever I've been a top I've always used a condom. Even though we both know that there's no risks really. He's a bit more conscious of being a bare bottom than, you know, bare top with me. And it's also because he's been a bare top previously with other partners and he doesn't like using condoms. But when it comes to being the other way around, it's not quite the same. But hey, I don't mind. It's fine. And you know, anything to reassure him. Anything to put his mind at ease

Raul (34, HIV positive)

Although TasP has been constituted as providing blanket protection from sexual transmission, independently of the risks of transmission without an undetectable viral load, Raul's partner's awareness of the asymmetry of risk between insertive and receptive anal sex, as well as his lack of familiarity with acting as the receptive partner translate into a perceived asymmetry of risk in the context of TasP. Raul acknowledges that this perception is not supported by their joint understanding of TasP - that there really isn't any risk - but is willing to support him to feel

comfortable in taking a more vulnerable sexual role by agreeing to continuing using condoms for this particular act. Matt also recalls feeling vulnerable when first having receptive anal sex with his partner.

When he fucked me, I would be panicking, thinking 'please don't cum inside me.' And I felt really bad about thinking that, I felt terrible. I think that since he came inside me and I let him and I didn't panic, things have changed between us. It's more equal now

Matt (45, HIV negative)

As with some other seronegative participants who had troubling thoughts or feelings about HIV or about their partners, Matt felt guilty for harbouring what he perceived to be a stigmatising idea. He did not voice his concern to his partner and, in going through the experience which he had previously feared, without experiencing negative consequence, his concerns passed, allowing him to feel closer. This suggests the importance of time and familiarity with serodiscordancy in relying on TasP in a relationship (Philpot et al., 2018). Matt's quote also speaks to the connection between of anxiety about potential transmission and the emotional labour of sex in a serodiscordant relationship, highlighting how a difference in HIV status further complicates a sometimes-fraught emotional landscape relating to sex. The focus of participants on their partner's satisfaction with their sexual relationship, sometimes at the expense of their own, in this section supports Giddens's formulation of relationships as constituted through mutual satisfaction (Giddens, 1993). Ensuring that their partner is satisfied sexually (and by extension with the relationship) is a way to support the continuation of their relationship and illustrates the emotional investment that partners make in order to achieve this.

'I feel safe with you' – TasP as sexual and relationship security

Giddens highlights modern intimate relationships as a source of ontological

security for those participating in them (Giddens, 1993). In contrast with the anxiety that Matt felt early on his relationship, this section focuses on how participants drew on their relationship to provide a sense of security and the role that TasP played in supporting these feelings of safety and stability, both in the present and in the imagined future.

Being in a relationship provided Muhammed with a sense of personal security and satisfaction. He contrasted his current relationship with his previous experiences, emphasising the importance of living together in providing the closeness and stability that he felt with his partner.

We live together, moved in together, and it feels on a whole new level from anything beforehand. And it feels very happy and secure. And trusting and loving. And I feel very happy to be in that space
Muhammad (30, HIV positive)

The happiness and satisfaction that Muhammad describes rests on both the love and trust that he and his partner share, but also in the sense of security that he derives from its stability.

As discussed above, many participants enacted the concept of TasP in electing not to use condoms when they had sex. For Raul, the first time that his partner had sex with him without using a condom symbolised a transition in their relationship and his partner's growing acceptance of his HIV status and commitment to him.

It was the first time that we had full-on anal sex without a condom [...] it just put a smile on my face all day long because that to me was so [meaningful]... a sort of a... turning point in our relationship
Raul (36, HIV positive)

In embodying the change in his attitude, the act of having condomless sex became an important milestone in their relationship and Raul's sense of security in it. Other participants found that being in a serodiscordant relationship, rather

than being troubled, brought a greater sense of satisfaction than they had experienced before.

When we first got together I was a bit more of a closed book because I'd been single for so long. But actually I've learnt [that] opening up, you have to let the guard [down]... what's the word for, you have to be vulnerable. That's the word. Make yourself vulnerable. It's actually making me feel ten million times more secure. I've always said to you [turning to partner], I've never felt more content in my life since I've been with you

Jim (37, HIV negative)

By necessitating conversations about topics which he had previously avoided and engaging with his fear of HIV in a new way, Jim found a deeper sense of security in his relationship. Other participants also projected their current relationship into a contented future, untroubled by concerns about HIV transmission or its effects on health. After his partner's diagnosis, Nathan embarked on an open relationship, which although presenting itself as a potential threat to the continuation of their 20-year relationship, he felt was not a threat to the intimacy and life that they had established together.

I assume we will continue until we end up in nursing homes or pop our clogs. One or the other. I don't think I see, even now, the casual sex side of it ever affecting that. I don't see it as a threat. Maybe [I] am naïve but I never really thought about it, I don't see any of it as a threat to us

Nathan (55, HIV negative)

Where participants felt that the future of their relationship was less certain, they emphasised how HIV was not one of the factors that placed its continuation in question. Robert (43, HIV negative) perceived some challenges relating to age and the possibility of his partner moving abroad for work, but otherwise felt that neither his partner's status nor his health in the future were potential problems

'the age gap and the [moving abroad] thing are the only things that cause me any sort of concern for the future.' Other participants perceived that HIV would not pose a threat to the future of their relationship, even if its serodiscordant status changed. Tom imagined a possible future in which his partner had become positive. He drew on his own experience of living with HIV to suggest that it would be unlikely to change his partner's life significantly, nor how they related to each other. His understanding of TasP meant that he also imagined that he would be very unlikely to be the reason that his partner's status changed.

I'm almost certain it wouldn't occur through me because we would be the one outlier across hundreds of thousands of cases, but like that might be a concern initially, like, 'oh shit was the science wrong? I put a lot of faith in that science!' But that's incredibly unlikely, so if it just happened through him hooking up with someone else it would be like fine, or I would actually be quite happy... obviously not happy, be happy that I would be able to be there for him as someone who's gone through that and, [be able to] reassure him, like that it won't really change his life. [...] Or our relationship, I don't think

Tom (26, HIV positive)

In addition to his experience of becoming HIV positive giving him confidence that a change in HIV status would not significantly change their relationship, Tom also emphasises the unlikelihood of his being the source of his partner's seroconversion. Although he sees his partner's HIV status as something that might change, his perception of the chance that he would cause it is low. This form of acceptance was echoed by other positive participants and stands apart from the experiences of positive partners in serodiscordant relationships in the past. Participants in other studies reported the possibility of transmitting the virus to their partner as a devastating one, which motivated many of their relationship practices in order to avoid this eventuality (e.g., Green, Aggleton and Davies, 1995; Davis and Flowers, 2011; Persson, 2013a). Even when

negative partners accepted the possibility that they may seroconvert, the feeling of responsibility on the positive partner remained. In this way, TasP can be seen to have transformed the experience of serodiscordancy for HIV positive participants in providing a reason to believe that they were unlikely to be the reason that their partner would become positive - even if they recognised that it could be a possibility from another source. I will explore how these considerations affected notions of responsibility for transmission within participants' relationships in the next section. However, for some participants considerations of potential future seroconversion were unimaginable. Their understanding of the biomedical prevention landscape meant that they could not even foresee the possibility that the negative partner would seroconvert, with the availability of PrEP and PEP as other avenues to prevent transmission or seroconversion should TasP fail or because of exposure to HIV from another non-relationship partner. Matt, when asked to imagine how he might feel if he did seroconvert, could not entertain the possibility - having imagined his response to any potential infection and his engagement with sexual health services.

I don't think it could happen because I would take PEP. I don't think it could happen. I don't think it could happen

Matt (45, HIV negative)

The unthinkability of becoming HIV positive in this situation has shifted from being unable to imagine life with HIV to being unable to imagine life changing to be HIV positive.

The data in this section has explored how the sexual safety that participants felt from their understanding of TasP supported feelings of relationship stability and security. By removing the possibility that seroconversion could disturb their relationship intimacy, participants could imagine a future in which their relationship was unchanged, providing them with a sense of security in the present.

These findings contrast with studies of serodiscordancy before TasP that theorised partners balancing 'viral safety' and practices that reduced transmission but disrupted intimacy with those that supported intimacy and provided a sense of 'relationship safety' (Cusick and Rhodes, 2000; Rhodes and Cusick, 2000). By alleviating concerns about viral transmission, TasP has transformed the way in which participants could maintain the sense of safety and security that their relationship provided them (Giddens, 1993).

'You've got to look after them too' – Negotiating responsibility

The practices outlined in the previous chapter show how participants incorporated the biomedical into their relationship and how they worked together to share the responsibility for the regular work of taking treatment through reminders and co-ordinated their engagement with HIV and sexual health services. These practices brought the biomedical into the everyday rhythm of their relationship and, in that process, made it unremarkable. Yet despite these practices, coupled with an understanding of TasP, developing a sense of familiarity and safety within the relationship, an asymmetry in relation to responsibility remained. Like many other HIV positive participants, although Terry subscribed to normalised ideas of HIV as a chronic condition, with a significantly reduced impact on health, he still perceived transmitting the virus to be something he personally wanted to avoid, which led him to occasionally feeling upset about his HIV status.

I want him to keep like that [HIV negative]... Of course I know a lot of other diseases are more serious now, but just this... I don't want to be the one who passes it on. So there are some moments that I feel down

Terry (33, HIV positive)

Even though HIV had become a regular part of Terry and his partner's

relationship, his status retained its potency as a threat to his partner's health. As with Ben's navigation in the previous section of HIV as normal, but still preferably avoidable, the interplay between normalising and stigmatising discourses of HIV provided a challenge for Terry to integrate into his feelings about his relationship. William also felt a responsibility for his partner which, although it focused less directly on transmission, was at its heart motivated by a desire to maintain his partner's negative status. By maintaining his own health and undetectable status, William protected his partner's health too.

There's this kind of unspoken responsibility in the relationship. Maybe it is just perceived [rather] than actual, but it feels like that there's this responsibility on you. You haven't just got to mind your own health, you've got to look after somebody else's health as well

William (32, HIV positive)

Thus, William's engagement with treatment took on an additional meaning for him. But his sense of responsibility even extended beyond the immediate management of transmission risk in their sexual relationship. William took an active interest in how his partner protected himself from HIV in encounters with other sexual partners, and through these discussions became more aware of the difference in their statuses.

There are occasional moments. Normally when we're talking about testing and PrEP and also when we're talking about negotiation of condom use with other partners. And that's when it really... it weighs heavily is not the right phrase, but [partner] is very conscious of his sexual health. And he will take steps to ensure that he is as safe as can be. So, for me when it comes to those kind of discussions and that kind of negotiation, it does... come to the forefront. Around that serodiscordant status

William (32, HIV positive)

Focusing on the additional care that William's partner's negative status required

to preserve it serves to emphasise the fragility of his negative status and, therefore, the need for him to play his part in preserving it. Raul and his partner also discussed the need for him to start taking PrEP if they open their relationship to outside sexual partners. Raul's sense of responsibility towards his partner's status here blends with a sense of possessiveness. In the careful way he phrases his resistance to Raul taking on responsibility for the both of them, his partner draws on ideas of fairness and for the need for personal responsibility in relation to sexual health.

I'm in two minds about it. Part of me thinks that he doesn't really need [PrEP]. And part of me thinks that he does. The part of me that wants to keep him for myself [laughs] says he doesn't really need it, obviously because I take care of both of us. But, we talk a lot and he's worded this brilliantly in the past, he says that he feels that he has to take care of himself. He doesn't see it as fair that I take care for both of us. Or... it's not a question of it being fair or not fair, he just needs to feel that he's in charge somehow

Raul (34, HIV positive)

Although TasP promises to disrupt notions of personal responsibility in sexual health, in practice individuality resists this disruption, empowering Raul's partner to assert his right to autonomy in relation to sexual health. Despite resisting the idea of an assumed responsibility for both partners, the careful way in which his partner persuades Raul of his need to maintain his own sexual health speaks to it as a personal matter of autonomy, rather than as a question of a lack of trust in Raul or in the efficacy of his treatment. This also speaks to the emotional dimension of an otherwise neoliberal construction (Adam, 2005), although both Raul and his partner recognize that it is 'right' for him to want to take responsibility for himself, his actions take on different meanings in the context of a relationship. Even in resisting some of the biomedical possibilities of TasP, Raul's partner recognises and accepts others. In the discussion above, I have argued that although TasP promises to expand the boundaries of responsibility

for HIV prevention beyond the individual and into a relationship, in practice this expansion appears to be a blurring that shifts into and out of focus in a couple's negotiation of their relationship and sexual practices. Imperatives of individual responsibility and of the preservation of an HIV negative status asserted themselves to disrupt new lines of expanded responsibility for HIV positive participants.

'You're not going to pick it up from them' – (Ir)responsibility transformed

This section examines participants' engagement with notions of responsibility relating to their sexual practices and examines how TasP provides an opportunity to transform boundaries of (ir)responsibility. It will also consider how some drew on these transformed conceptions in the boundary work they performed around their relationship.

Notions of safer sex have been shown to be bound up with moral and political judgements, for example discourses that emphasise individual responsibility align with neoliberal imperatives (Adam, 2005; Keogh, 2008a; Adam, 2016). This section interrogates how participants drew on TasP to articulate new forms of safer sex in the transformed risk landscape. In describing these turns and transformations of responsibility and new ways of 'doing sexual responsibility' I seek to explore how participants renegotiated ideas of (ir)responsibility and in doing so engaged in new boundary work to define themselves in relation to an 'irresponsible' other. In doing so I am not seeking to make ethical judgements around these new positions, but through this analysis hope to show how transformed biomedical identities made available via TasP in combination with social processes such as boundary work shift and redefine notions of responsibility.

Gary described how learning about TasP helped him to manage the negative

emotions he had associated with his sexual practices after being diagnosed with HIV. Knowing that he would not pass on the virus helped him to redefine his own perception of infectiousness and reframe any condomless sex as less risky.

[I had] the thought that I do have this infectious thing in me, but on medication, [being] undetectable... that made it, I guess, a bit more mentally easier to sort of start, you know, not living recklessly, but ... I don't know what the word is. Not feeling... guilty isn't the right word for what was going on before. But it's just a bit... you could do things a bit more responsibly knowing that I was taking the medication and [was] not going to, you know... endanger is the wrong word, but... you kind of get the gist of what I mean

Gary (41, HIV positive)

The hesitancy of his language here suggests perhaps an uneven or incomplete transition from 'endangerment/guilt' to 'responsibility.' However, the transformation in Gary's personal framing of infectiousness has more recently been reflected in the attitudes and knowledge of others he and his partner have sex with, '*you know... [we] just use the undetectable term and people tend to recognise that and understand it and, you know. And... it just makes the whole thing a lot easier.*' TasP has enabled the transformation of identity of someone living with HIV from a potential source of infection to, via an undetectable viral load, being responsible and risk-free. Although TasP prevents HIV transmission whether or not condoms are used, risks to sexual safety posed by other sexually transmitted infections persist. As with Gary, William used his understanding of TasP to resist the construction of himself as a source of HIV infection. However, he was sanguine about the risks of acquiring and passing on other sexually transmitted infections through condomless sex. Yet rather than presenting the lack of condom use as irresponsible, he drew on individualised discourses of responsibility to argue for an approach to sexual safety which foregrounded personal choice, biomedical surveillance, treatment and open partner communication.

If I choose to have condomless sex with somebody, I know that there's a risk of transmitting [STIs] to [partner] and vice versa. We have already been through that process together. [Partner] got a little bit into the kind of, 'ooh, who might it have been,' and... I'm like, 'anyone or everyone could have...' All you need to do is go and get your treatment, inform your partners, done. Yeah. And once you've ticked that off you've done everything you're personally responsible for

William (32, HIV positive)

In finding new ways of 'doing sexual responsibility' (Robinson, 2018) in the era of TasP, these participants used new undetectable identities to resist discourses of 'recklessness' in relation to condomless sex but continued to draw on notions of individual autonomy and responsibility to reframe sexual risks in terms of their obligations to engage in biomedical surveillance and communication with sexual partners. HIV prevention has been the main focus of public health discourse around safer sex in gay and bisexual men, with the question of other sexually transmitted infections a subordinate concern. For participants who viewed condoms as unnecessary for HIV prevention, the question of how to conceive of the risk posed by other sexually transmitted infections arose. Some participants were mindful of the specific health effects of other sexually transmitted infections, such as hepatitis C and syphilis, either due to family histories of liver disease or friends who had experienced reactive arthritis after a syphilis infection. In this way, participants drew on their biographies to make sense of and contextualise the risks of 'other STIs' in a landscape in which HIV was no longer the main concern. In the absence of a clear message from public health, participants made their own answers to the question of the relationship between HIV and other STIs in the era of pharmaceutical prevention. Through this rhetoric they engaged in boundary work to redefine notions of responsibility beyond HIV status and condom use. In foregrounding engagement with biomedical technologies of treatment and testing couples with social approaches, such as

the importance of communication between sexual partners, they advanced a modified picture of what it means to be a 'healthy homosexual' (Keogh, 2008a). In this approach, rather than assuming that they and all their partners were a potential source of infection and relying on consistent condom use to reduce risk (Flowers, 2001), participants instead sought to reduce their exposure to 'the unknown'. This functioned both on an intimate and a biomedical level. Firstly, by engaging with regular sexual health screening, participants could monitor and make known their own risks. By seeking partners who also engaged in regular testing and who discussed and shared their practices, participants gained not only biomedical knowledge of their partners, but also a sense of understanding which overcame concerns of 'the unknown'. In this setting, as a 'known' but managed risk, someone HIV positive but undetectable could be brought within the boundaries of responsibility in a way which previous conceptions of sexual safety would not allow. This 'deep knowing' of self and of your sexual partners echoes and extends ideas of 'deep knowing' and disclosing intimacy into the biomedical (Giddens, 1993; Jamieson, 1999). Conversely, not engaging in screening, or not engaging frequently enough (and therefore being unaware of your potential infectiousness) becomes a mark of irresponsibility. Accordingly, not engaging with sexual partners sufficiently deeply to understand their risk management practices also becomes a risky practice. These engagements with biomedical and intimate 'knowing' redefine and reify the 'risky' individual as one who does not engage in open communication, regular testing or who engages in anonymous sex. This redefined way of 'doing sexual responsibility' is brought to life in Ben's account of selecting potential sexual partners to join he and his partner, an approach he presented as being '*responsibly irresponsible*.'

We tend to sort of choose other guys who are either on PrEP or [are HIV] positive. Because, I really don't want him picking up HIV and I thought, well, guys who are on treatment or guys who are on PrEP, you're not really going to pick it up from them. I try and screen them because... when we first started to play around with guys, we had a

guy who came around quite a few times and we got on with him really well. But as he became more comfortable with us, he began to open up with us and he was actually really irresponsible. He'd go to bareback parties and have sex in an evening with over 20 guys. And things like that. And I just thought, he's horny, he's wonderful in bed, but he's a time bomb

Ben (48, HIV positive)

In creating new ways of understanding and managing their sexual practices, these participants describe innovation akin to the strategies of 'serosorting' and 'strategic positioning' that developed as ways for individuals to more actively engage with discourses of sexual safety and personal experiences of intimacy. Tom also engaged in a creative response to notions of 'doing sexual responsibility' which emphasised the role of HIV positive men in disclosing their status before engaging in sexual activity. He drew on TasP and undetectability to question this obligation and to support his decision not to engage with it when looking for threesomes on-line.

I would rather not say anything [on Grindr]. Because what's the worst that's going to happen? They're going to see my pills on the side while they're fucking me, and they'll ask, and I'll tell them and then if they freak out then, like... that's their issue. I'm not putting them at any risk

Tom (26, HIV positive)

In locating any 'issue' with his status in the imagined third party, Tom is both emphasising the importance of individual responsibility but transforming this expectation of taking responsibility for one's practices to also taking responsibility to be educated about and understand the transformed risk landscape wrought by TasP.

‘Are we being blasé?’ – U=Uncertainty

This section draws out participants’ engagement with TasP and U=U in the context of their relationships and focuses on areas of uncertainty and concern. It will examine how participants reconciled their relationship practices – particularly sexual practices – with their understanding of the principles of TasP and how they negotiated gaps in their knowledge. It will examine instances where TasP inverted understandings of risk and safety as well as moments in which the sense of security that it provided suddenly disappeared. In these moments, not only does the threat of HIV to health emerge, but in threatening the ontological security (Giddens, 1993) provided by the relationship, these threats became ones to participants sense of self.

All participants in the study were aware of the concept of TasP and some were actively involved in communicating this idea more broadly under the community banner of U=U. Participants emphasised different elements of TasP and incorporated it into their relationship practices in different ways. Although TasP has at its heart a concept of certainty - that someone HIV positive with an undetectable viral load is unable to transmit the virus, in practice participants experienced varying degrees of uncertainty around the implications of this for their relationship and their future.

For participants Chris and Charles, who routinely did not use condoms when they had sex, the knowledge that there was no risk of transmission was almost too good to be true; they occasionally doubted whether their practices really were safe.

I know I'm clear I don't want the virus. So I guess that is a big thing isn't it. I'm not blasé about it, I don't want the virus. And I sometimes wonder if I'm being blasé, being in a relationship, being unprotected in the relationship with [partner]

Chris (51, HIV negative)

*The reassurance is the viral load checks. We don't use condoms.
And it's really nice to be in a relationship like that, where those
things don't seem to matter. I might have missed why it should
matter, but I'm not aware*

Charles (41, HIV positive)

In a similar way to participants finding themselves between two mutually exclusive images of HIV when they first encountered serodiscordancy (pathological versus normal), Chris and Charles's doubts around whether their practices are sensible or mistaken seems to arise as they try to reconcile the mutually exclusive formulations of condomless sex, formerly risky for HIV transmission, now (in the context of an undetectable viral load) risk free.

In addition to uncertainty about TasP itself, a number of participants were unclear on how the principle operated in general, or in reference to their particular situation. Uncertainty included around how quickly undetectability might be achieved and, conversely how quickly it could be lost and under what conditions. Others wondered about the applicability of the principle of sexual uninfectedness to other modes of transmission, such as through blood. Other participants wondered more generally about how HIV might affect them or their partner in the future or if, should the negative partner become positive, whether their experience of the virus would be the same as their partner's. The certainty inherent in TasP translated into multiple uncertainties around particular circumstances: the risk of transmission of particular acts became liminal rather than definitely risky or definitely safe; the stability of an undetectable status became a location of concern and other factors outside of TasP became more important in participants' understanding of the virus in the context of their relationship.

TasP as a potential role reversal

The biomedical transformation of the risk landscape of HIV has, in some instances, been so radical that participants reflected on how patterns of risk and concern had become reversed. William discussed how the advent of treatment allaying concerns about the health impact of the virus led to the greatest focus of concern being the preservation of his negative partner's status, rather than his own health.

A lot of the difference in the status is quite underlying, it's really almost unconscious and subliminal when it comes to the difference. I mean, 10, 15 years ago that would have been a whole different scenario. But now it's almost on a par. And in actual fact we're in a position where I'm worrying about my HIV negative partner, whereas 10 or 15 years ago [there would have been] an entire role reversal

William (32, HIV positive)

The contrast between the culturally dominant image of someone living with HIV as fragile or at risk of ill health contrasts ironically with William's experience of his own health and the fragility of his partner's negative HIV status. Richard also reflected on how being undetectable, with its implications for health and uninfectedness, led to a state of comfort and unconcern, which contrasted with his perception of the virus when he was HIV negative.

It was the thing that we were always afraid of... and now we've faced that fear... it's almost to have a weight lifted

Richard (46, HIV positive)

These reversals are echoed in Jim and Santiago's experience of serodiscordancy, in the context of considering an open relationship. Whereas when he first learned of his partner's positive status, Jim was anxious and felt threatened, he now feels a sense of safety. The prospect of having sex with partners of unknown HIV status brings back his concerns about HIV transmission.

(Jim) It's a strange flip for me [...] 12, 13 months ago where I was 'whoa, blimey!' when you told me. [...] To now, like I forget. But, I sort of feel a bit protected.

(Santiago) It's funny that you feel protected by me.

(Jim) Yeah.

(Santiago) It's just funny. Because the tables have turned so much haven't they?

Jim (37, HIV negative), Santiago (34, HIV positive)

The rapid adjustment and remaking of Jim's worldview echoes the transformation of medicalised discourses of HIV through the biomedical. The rapidity of the changes and their confinement to specific social groups, such as those with direct experience of HIV, may explain the experience of them as somehow disorientating, flipping previously accepted or widespread conceptions of what it meant to be HIV positive and the risks of viral transmission. The sense of disorientation and conflicting ideas as to what HIV means for an individual's health or their relationships echoes the findings of a study into the experiences of being diagnosed with HIV in the era of treatment. Participants described a sense of discontinuity between the reassurances about the biomedical normalisation of HIV they received from healthcare professionals at their diagnosis with the feelings of anxiety, guilt and shame that they experienced when learning about their status (Walker, 2019). These experiences add to those described above to show how the further biomedicalisation of HIV is affecting the social and emotional meanings ascribed to the virus. As Clarke and colleagues (2003) describe, these meanings are bounded and predicated by what has come before and are not determined by the biomedical transformation itself. This stands in contradiction to the expectations of TasP and U=U which promise to abolish stigmatising images of HIV with the promise of 'untransmittability' and further illustrates the argument I made in Chapter 2 that these scientific concepts neglect the social context in which they operate. Yet the magnitude of the transformation participants experienced – a complete

inversion of risk and of vulnerability – points to the potential of TasP to make dramatic changes to experiences of serodiscordancy, a sense in which ‘the world has changed’ (Persson, 2016). The uneven way in which understandings of biomedical transformations are spread through society leads to the co-existence of different HIV knowledges organised around patterns of engagement with the virus. I will explore how participants engaged with this idea in order to define boundaries of (non)disclosure to others in Chapter 7.

Spectres of HIV

Participants describe some instances where, despite HIV not being an issue in the normal course of their relationship, it has suddenly or unexpectedly occupied their thoughts. These occurred to both HIV positive and HIV negative participants. There were moments in which HIV, despite its absence, made its presence felt in particular moments. These spectres of HIV loomed and threatened – focused on potent symbols of infection and transmission, suddenly bringing fears about the virus to the foreground once more.

For some participants these thoughts occurred in relation to sex, in particular about the HIV positive partner’s cum.

*To be honest whenever [I] top if I don't use a condom, I always have
a moment of worry [...] It shouldn't be risky because I'm
undetectable, but I don't know for sure at that moment whether I
am. So I think cumming raises the risk. And I would feel so guilty if
he really got it just because I want that pleasure*

Terry (33, HIV positive)

The intangibility of his undetectable status meant that Terry had room for doubt during moments where he was aware that there would be a high risk of HIV transmission were he not. The guilt Terry would feel were his partner to seroconvert looms and causes his anxiety. As well as wanting to protect his

partner's health, Terry's anxiety also takes in the possibility of his 'selfish pleasure' unbalancing their relationship that would otherwise be founded on 'mutual give and take' (Giddens, 1993). Viewed in this way, his 'greediness' could be a threat to the stability of the relationship as well as to his partner's status.

Chris also experienced a moment of uncertainty shortly after having had condomless sex with his partner.

Last night we had sex, unprotected, and I was the passive partner and he came inside me. And I noticed that just for some reason I didn't want to go to sleep with [his cum] in me. I kind of had this, kind of little, not a huge, anxiety. I just thought I don't want to go to sleep with it in me

Chris (51, HIV negative)

Chris emphasises that the concern he felt about going to sleep with his partner's cum still inside him was not on the scale of the anxiety he had previously felt about the virus. Nevertheless, his perception of the potential risk posed by allowing his HIV positive partner's cum to remain in his body for long motivated him to get out of bed and visit the bathroom. Laurence (37, HIV negative) also discussed how even though he understood that his partner's viral load meant he was uninfected, when he encountered his cum, the idea of risk returned.

Generally I won't receive semen in my mouth. And probably I'm a little bit more conscious of it, which... It's that thing of about the brain says it's fine, I'm OK with it... to there's the other primal bit going, oh there's that sort of [scary] thing lurking in there

Laurence (37, HIV negative)

In pointing to a 'lurking' presence in his thoughts, Laurence disavows the concerns as foreign to his rational mind. In 'A sociology of nothing: understanding the unmarked' Scott (2018) argues that 'nothing' constituted by three negatively defined phenomena (non-identification, non-participation, non-presence) is a neglected but sociologically productive phenomenon. Focusing

on absence, she describes how absent objects sometimes reappear – looming large in consciousness as ghost or apparition.

'Ghostly figures can be discursively constructed and invoked to create a climate or moral panic, labelling and deviancy amplification: alluding to people who are not there but whose imagined apparition carries a silent, lurking threat... Scenes of nothingness are reimagined as potentially dramatic social events, just waiting to happen.' (Scott, 2018, p. 11)

As well as telling us about the ways in which participants seek to navigate risks that they perceive, these experiences also illustrate the way in which successive transformations wrought by the biomedical do not operate monolithically, sweeping away old understandings, but instead modify and are modified by what has come before. Terry, Chris and Laurence's navigation of post-TasP serodiscordant sexual intimacy is influenced and guided by their understanding of the nuances of risk associated with HIV positive cum gained in the pre-TasP era. This example suggests a further way in which the transformations of intimacy rendered by the biomedical are incomplete and partial: on the scale of the individual and across time. While Chris 'knows' that TasP means there is no risk from his partner's cum, his emotional response to it relates to his understanding of it as a threat to his health. Terry's perception of himself as a threat to his partner's health occurs during sex rather than at other times. Engaging with the everyday in this way provides insight into the equivocal, messiness of intimacy and, critically, the way in which biomedical certainties can become 'unstuck' in the ongoing realm of lived experience, which I will return to in my conclusion.

Summary

This chapter has considered how participants practiced sexual intimacy in and around their relationship. It has explored the role that sex played in participants' relationships and the emotion work that they engaged with around their sexual

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practices, particularly the type and frequency of sex. As in other studies, sociocultural conceptions of the importance of sex for a 'healthy' relationship and gendered ideas of a male sex drive that demands satiation were present in the way that participants framed their sex lives. Yet in articulating their practices, many drew on the principles of the 'pure relationship' (Giddens, 1993), particularly their emphasis on finding 'what worked for them' independent of external referents. Considering their sexual practices through the lens of mutual satisfaction also makes sense of the way in which compromises formed a regular part of participant's sex lives: sometimes placing your partner's satisfaction above your own not only demonstrates your understanding of their desires but also serves to cement their commitment to a relationship that could otherwise dissolve. Yet where the 'pure relationship' emphasises equality in give and take, this idea was complicated by a range of 'inequalities' relating to age, health and relationship duration as well as of serostatus. For some participants, their relationship becoming serodiscordant led to them reducing or changing their sexual intimacy. Adopting alternative relationship formations, with varying degrees of openness, helped some participants to sustain their relationship in the absence of sexual intimacy between partners. In these contexts, talking about and agreeing 'rules' of an open relationship provided opportunities for partners to demonstrate their 'deep knowing' of one another's desire and frame it as a thoughtful act of care. In considering the place that participants ascribed to sexual intimacy I have argued that, in a similar way to other men in same-sex long-term relationships, they negotiated the sometimes complex and contradictory place of sexual intimacy and the waxing and waning of desire through emotion work and in the context of other forms of intimate practice which sustained relationship intimacy.

This chapter also looked in detail at how they navigated interconnected landscapes of risk and responsibility in light of the transformations wrought by TasP. I have suggested that participants adapted practices and behavioural

strategies from the pre-TasP era. Thus, rather than a sweeping away of risk, participants renegotiated what 'responsibility' looks like in the context of a (monogamous or open) serodiscordant relationship in dialogue not only with the risk of HIV transmission but also broader considerations of sexual health and intimate knowledge of sexual partners. I have argued that through their practices, participants were continuing to 'do sexual responsibility' and this boundary work allowed them to gain a sense of 'irresponsible responsibility' at the expense of those they constructed as 'truly irresponsible.' Although relationships and serodiscordancy through their relationality trouble individualised public health discourses of responsibility, I have suggested that the renegotiated boundaries still draw on the same public health rhetoric to mark some acts of condomless sex as an acceptable risk. The renegotiation of boundaries of acceptability and responsibility independent of serostatus has been suggested by others, as well as their redefinition in terms of engagement with the biomedical (Guta, Murray and Gagnon, 2016; Persson, Newman and Ellard, 2017; Bereczky, 2019). These papers highlighted the risk of demonising those who were HIV positive with a detectable viral load due to a lack of treatment or a desire not to be treated. In the data I have explored here, the focus of participants' concern seemed less focused on HIV and more on the risk of other transmissible infections posed by individuals not engaged with testing. This was coupled with a sense that those not engaging in testing in this way were not upholding standards that participants subscribed to, disqualifying them from an imagined 'community of care' (Davis, 2008; Boydell, 2014).

In considering how participants in open relationships conceived of and managed risk in a context of condomless sex, I have argued that in 'doing sexual responsibility' (Robinson, 2018) participants were engaging in boundary work around new biomedical identities that TasP and PrEP gave them access to. Considering these redrawn boundaries of 'responsible irresponsibility' indicates that although TasP, through U=U is ultimately a tool through which stigma is

transformed and transferred, rather than tackled or reduced. The dyadic nature of serodiscordancy and, particularly of TasP, troubles notions of individual responsibility which underpin public health discourses around HIV prevention and sexual health. By reinscribing boundaries and enforcing them through non-engagement or judgement of (ir)responsibility, rather than overturning prior HIV prevention discourses, participants' practices were drawing on and reinforcing them.

Finally, this chapter examined the ways in which uncertainty arose for participants in relation to TasP and their sexual practices. In his example of a lesbian relationship, Giddens highlights a downside of a relationship conducted without reference to external considerations: although it affords partners freedom to define their own standards, the absence of external 'yardsticks' can be a source of uncertainty (Giddens, 1993). As I argued in Chapter 2, although TasP and U=U are concepts that are built on serodiscordant relationships, as scientific principles they neglect the social and intimate contexts in which they are to be realised. These both feed into the uncertainty that participants felt around incorporating TasP into their sexual practice, in the absence of role models or guidance around what they *should* do, they had no way to ratify – other than their own understanding of TasP – what they *were* doing. Layered upon these wider concerns were particular moments of uncertainty which some participants reported during or after sex in relation to the safety of what they were doing. The dramatic change in understanding of risk that TasP has brought about was perceived by some as a topsy-turvy inversion of who and what was safe and risky. These new understandings were sometimes replaced with older images of risk, particularly relating to potent symbols of risk, such as HIV positive partners' cum, in a way that I have argued resembles 'spectres' of HIV. The virus, perceived to be absent in the everyday (as outlined in Chapter 5) suddenly returns, leading to participants questioning how much they can trust in the certainty that TasP promises in the provisional, ongoing everyday.

7. 'Doing serodiscordancy' at the boundaries: managing identity to navigate stigma

Happy!

I met a guy

Conversation flowed

Should I tell him about my status?

I fear communicating my situation

He might tell people, I won't like it

I love people around me

They keep me happy

Some friends know my status

They support me and I know

I am not alone

I told him my status

He was asking loads of questions

He wants to know more about U=U and PrEP

Sounds like he has been doing some research!

It feels good knowing I can talk to him about it

He has been texting with questions about HIV

He seems ok with my status

I don't know everything about HIV but I am learning with him

We are going on another date

'Happy' – Talking Together (Positive East, HIV Voices)

The poem above, written by a participant in a community programme for people in serodiscordant relationships to tell their stories and tackle stigma illustrates a number of considerations for HIV positive people in serodiscordant relationships. The first, whether or not to tell a partner about their HIV status, is a complex one. Fear of rejection, feelings of shame and anxiety about transmitting HIV have all been reported by people living with HIV when starting new relationships (Auzenberg *et al.*, 2018). Because 'reckless' HIV transmission remains criminalised in the UK, there is a legal, as well as perceived moral burden on people living with the virus to reveal their status to their sexual partners (Keogh, 2008b; Dodds *et al.*, 2009), even though the data supporting TasP suggest that the risk of transmission from someone undetectable is essentially zero (Rodger *et al.*, 2016, 2019). Although some suggest that being open about a positive HIV status is beneficial (Przybyla *et al.*, 2013), the poem highlights that many people living with HIV choose not to tell everyone about their status. UK survey data suggests that of the 87% of respondents who shared their HIV status, 60% told their sexual partners, 56% told family members, 52% told friends, and 17% told others, such as co-workers and neighbours. There was a trend towards a difference between the genders, with women more likely to tell family but least likely to tell their friends and partners. In contrast, men were most likely to tell their friends and partners and least likely to tell their family (Kall *et al.*, 2020). The poem also touches on issues of education and awareness about HIV, TasP and other forms of HIV prevention and who is responsible for providing information. As with the burden of disclosure, the burden of educating potential partners about HIV often falls to people living with the virus (Bourne *et al.*, 2009), although as the poem suggests they themselves sometimes feel unequipped, or unwilling, to provide potential partners with information.

I have discussed in other chapters how although stigma and normative views of HIV did not feature prominently in participants' everyday experiences, they inflected the way in which they practiced their relationship. In this chapter, I turn

to the practices, emotion work and boundary work that participants engaged in in order to manage stigma relating to HIV and serodiscordancy. These were associated with two distinct but related parts of participants' lived experience: at the beginning of their serodiscordant relationships and in encounters with others outside their relationship. I will first discuss how participants engaged in emotion work at the beginning of their relationships (both those that begin as serodiscordant and those that became serodiscordant) and how these were differently patterned for participants with different serostatuses. I will then consider participants' practices around telling others about their serodiscordancy and how its dyadic nature sometimes troubled and even inverted pre-existing mores around disclosure and confidentiality. In order to manage their serodiscordant identity, participants engaged in practices of telling/not telling others about their serodiscordancy. Whereas the rhetoric of U=U promises that knowledge of TasP will dissolve stigma, I will argue that participants were more circumspect about who they raised issues of serodiscordancy and TasP. I will discuss how they engaged in boundary work, sometimes actively bringing others in, at other times excluding those who they perceived to be 'ignorant'. Finally, I will consider how some participants drew on U=U and its promise of reducing stigma through raising awareness of TasP to share their stories more widely and how this aligns with Plummer's theories of liberation through 'telling sexual stories' and intimate citizenship (1995, 2003).

'I knew this conversation had to take place' – The emotion work of disclosure

HIV status is something that can be hidden, a discreditable stigma (Goffman, 1963). Those living with the virus can therefore choose not to reveal about themselves and preserve an unstigmatised social identity. Although this research included participants who were aware they were in a serodiscordant relationships, survey data suggest that not all HIV positive men in relationships

tell their partners about their status, with 68% of men (including both gay, bisexual and heterosexual men) telling their partners about their status. 'Reckless' transmission of HIV is currently still a criminal offence in the UK and disclosure to sexual partners is sometimes interpreted as a legal requirement (Dodds et al., 2009; Bernard and Bennett-Carlson, 2012), but putting this to one side, the decision-making process around status disclosure has received significant attention, not least because it has been implicated in the propagation of the epidemic. Researchers have constructed decisions to conceal or reveal an HIV positive status as evidence of an individualised neoliberal approach to risk (Adam, 2005) but others have advanced an account situated in a community of care (Davis, 2008). Participants assumed that it was the job of the HIV positive partner to initiate a discussion about their HIV status. This reflects wider societal norms that individuals are assumed to be HIV negative unless told otherwise (Flowers, 2001). This assumption holds true even in a group of gay and bisexual men, in whom HIV is more prevalent than the general population.

Although Owen had told his partner about his status, he found that being undetectable complicated his approach to disclosure. On one hand it prevented transmission of the virus, thus in some ways relieving him of the need to disclose - if there is no risk, there is no need to warn people about it. On the other, he still felt an ethical imperative to disclosure. This placed him in a dilemma about how to behave with partners he might not meet again and to whom his status could be argued to be irrelevant. However, in the context of an ongoing relationship, there was no question of not telling his partner his status.

And part of it was when [do] you bring it in, because if it's just a casual meet, do you broach this? Or if you're on meds and it's undetectable, untransmittable is there a problem? But because I'm very ethical, it is a problem. So when [partner] said he wanted a deeper relationship and I wanted a deeper relationship I knew this conversation had to take place

Owen (60, HIV positive)

By distinguishing different expectations for one-off sexual encounters and lasting relationships and calling upon discourse of ethical behaviour, Owen is both drawing on biomedicalised safer sex imperatives for gay and bisexual men and also broader social discourses about how relationships should be done. His ethical conflict over disclosure of his status speaks to his navigating conflicting models of safer sex. In one, an approach that has been characterised as the 'neoliberal sexual actor' (Adam, 2016), individuals are responsible for managing their own risk: in this case, his undetectable status manages any risk and thus negates the need for deeper discussion. In an alternative conception, more focused on community ethics of care and mutual discussion, withholding information such as HIV status would prevent an open discussion taking place between partners and is therefore unethical. However, for Owen, the calculus of telling or not telling shifted when he considered a primary relationship. Any conflict over disclosure is trumped by the idea that successful relationships are founded on transparency and openness. Giddens's and Jamieson's concepts of 'deep knowing' and 'disclosing intimacy' speak to this idea that only through total disclosure and transparency can true relationship intimacy can be achieved (Giddens, 1993; Jamieson, 1998). Thus for Owen only by revealing information about himself that he otherwise kept hidden could he enter into the deeper relationship with his partner that they both desired. Not telling his partner would mean their connection would be somehow less deep - his silence about his status would be dishonest. Where Giddens emphasises popular psychological discourses about self-knowledge and truly understanding your partner as the way to achieve relationships satisfaction, Jamieson is more critical of the move to disclosure and emphasises other ways of developing and maintaining relationships, such as practical caring, which do not rely solely on revealing intimate information. Yet as Owen's experience suggests, the idea that a successful serodiscordant relationship is one in which both partners are aware of their HIV status places disclosure as a key criterion and is a concept of serodiscordant relationships that pervades other participants' accounts. Owen's

construction of the process as a conversation also highlights the inter-relational quality of 'telling' and points away from simple conceptions of 'disclosure' towards a more connected understanding of this process in the context of a relationship. That 'deep knowing' of someone extends to knowing their positive serostatus reflects the normative nature of a negative HIV status and the way in which HIV becomes part of people's identities (Flowers and Davis, 2013; Persson, 2013a).

Reaching a state of acceptance is a common theme across many accounts of participants' first encounters with serodiscordancy. Although some participants' past experiences have provided examples of relationships in which acceptance was not reached and the relationships dissolved, in this sample participants were in relationships that had continued with serodiscordancy at their heart, despite some experiencing initial problems.

Within weeks, probably, of us forming a serious relationship. I told him. And he was very disturbed about it. Very upset. And I think he discussed it with a few friends who said it was stupid to continue the relationship, but he obviously did. And we've come to terms with it

Justin (76, HIV positive)

Here Justin presents the coming to terms with as a state that has been achieved jointly, both his partner coming to terms with his HIV status, but also potentially Justin coming to terms with and accepting his partners initial discomfort and upset. Other participants present the acceptance of serodiscordancy as occurring even earlier in the formation of their relationships and being a rapid, if not instant process, as was the case in Robert's experience when he was introduced to his partner by a mutual friend arranging group sex.

A mutual... fuck buddy for want of a better phrase... decided that he wanted to arrange a foursome [...] [partner] divulged his status before we had the group sex and it was of no concern.

No issue for me

Robert's acceptance of his partner's status is effortless in the moment in which it occurs, however it was not always the case. Robert recalled a previous encounter with an HIV positive man in which he was unable to accept his status, based on his unfamiliarity with the virus *'I didn't know enough about it and I struggled relaxing and being comfortable with everything.'* Robert credits engagement with biomedical HIV prevention via discussion of transmission risks with sexual health physicians and starting to take PrEP with his understanding of HIV, leading to an understanding of it as less of a threat. This led to a feeling of greater comfort with the idea of having a partner of a different status. His easy acceptance rests on a process of learning and familiarisation. Thus processes of disclosure during relationship formation, rather than being a 'fateful moment' (Giddens, 1991) becomes an extended dialogic process contingent on prior experiences and familiarity with HIV. Fateful moments stand in contrast to the everyday in which meanings are made (Gabb and Fink, 2015a) and this analysis suggests that these processes are better understood through the lens of 'ordinary moments' instead.

The HIV positive men in this study described a fear of rejection in their experiences of discussing their HIV status beginning their current relationship. Being HIV positive in and of itself was a potential 'deal breaker' and sufficient reason for someone HIV negative to reject them; their status made them less eligible to be in a relationship. This idea rests on stigmatising discourses of people living with HIV being 'less than' and unworthy of being in a relationship. Such ideas are not specific to the UK context: In a study of gay men in serodiscordant relationships in Peru, Konda and colleagues (2017) also found an expectation that disclosure of serodiscordancy by the positive partner would prompt the negative partner to leave, thus placing the future of the relationship in doubt. These perceptions underlie the desire to avoid infection among both HIV positive and negative men. The possibility of disclosure leading to rejection

was more than an idea for many men, having experienced it with other partners in the past. Each new relationship carried in its beginning the threat of a premature end. Matthew found that although the strong negative emotions he anticipated in reaction to him telling a prospective partner his status did not materialise, nevertheless, his status led to formative relationships coming to an end.

*I never had a bad experience where people got angry or whatnot.
But I definitely had... there were two people in particular that I can
think of... you think you're getting to a certain stage and they go,
'actually no. I can't deal with this'*

Matthew (30, HIV positive)

Thus, for Matthew, and for many others, revealing their HIV status had been a point of potential disruption the development of a relationship with an HIV negative partner. As with Owen, for Matthew disclosure is part of a process of mutual discovery and deepening bonds during relationship formation, but here rather than the conversation that took place between Owen and his partner, Matthew constructed his experience as an agreement broken off. In telling these prospective partners about his status, he had altered the balance in the nascent relationship, disempowering himself and handing them the opportunity to decide whether it continued or not. This imbalance rests upon a societal view that an HIV negative status carries a greater inherent value than a positive one and empowers decisions accordingly, patterning intimacy through public discourse (Plummer, 2003; Davis and Flowers, 2011). In *Telling Sexual Stories* (1995), Plummer discusses how sharing personal experiences has the potential to transform societal views of stigmatised groups. These processes operate through the public sharing of private experience and Owen and Matthew's experiences relate to sharing in personal contexts. However, the public and the personal are interconnected (Plummer, 2003) and individual acts of talking about serodiscordancy can be mobilised in the service of social change, as I will explore

later in this chapter (see *Deploying serodiscordancy as advocacy*).

A counterpoint to this imbalance is provided in Brian's past experience of dating positive guys before his current relationship. Brian found his status was a barrier to his prospective partners.

During my time in London I did try to date a couple of guys who were positive, and it became clear that me being negative was a real problem for them. One of them, quite spectacularly. He just couldn't date a negative guy

Brian (41, HIV negative)

In reporting himself as reduced to 'a negative guy' and on this criterion alone rejected as a suitable partner, Brian constructs HIV status as the main, potentially only reason that these formative relationships did not work out. Although he credits his positive partners as the main drivers of the break-up, it is also his assessment of their behaviour that places the difference in status as the critical issue. While the direction of rejection runs counter to common narratives of serodiscordant dating and empowers the HIV positive men, by showing himself to be 'willing' to date positive men, Brian retains his agency in the situation, which still displays a bias against negative men entering into a relationship with those with an HIV positive status. Similarly, by hinting at a 'spectacular' break-up, Brian portrays his former partner as emotionally unable to cope with the stress of dating a negative man, suggesting that not only are serodiscordant relationships challenging for partners, the burden is asymmetrically placed on HIV positive partners. Brian's story complicates the simple story of relational agency relating to serostatus that emphasises the power of HIV negative partners in relationship intimacy (Cusick and Rhodes, 2000; Davis and Flowers, 2011). Agency involves partners being active participants in structuring their relationships and demands a more dynamic understanding of power than those that, for example, use reductive ideas of gender to understand heterosexual

relationships (Heaphy, Smart and Einarsdottir, 2013). This further underlines the importance of understanding serodiscordancy as a relational phenomenon, rather than an analysis split by serostatus.

Although experiences of uncertainty about how a partner would react to the news was common, there were also situations where participants felt that partners were not ready to hear about their status, or would definitely react badly. Raul (34, HIV positive) had begun a causal relationship with his partner and had not yet discussed his status. Hearing his partner and his friends talk about HIV in a careless way signalled to Raul that he might hold negative perceptions about people living with HIV and that he should be careful not to reveal his status. Rather than correct what he and his friends were saying, Raul stayed silent to avoid signalling his familiarity with HIV.

[Partner], me and another friend [were out] ... and in conversation came up that his flatmate had had sex with a mutual friend who is HIV positive. And both [partner] and this friend were displaying sort of misinformation [...] I could have overtly sort of said, 'look the facts are these and I know this because of this and that,' but I didn't at the time. Because at that time I was just sleeping with [partner] and... it wasn't the right time. Erm. But it set all the alarms off for me

Raul (34, HIV positive)

As with Owen's navigation of the need for disclosure, Raul's assessment of his relationship with his partner as 'just sleeping with' him helped him justify staying silent in a situation in which he might otherwise have spoken up. Rather than just being about whether or not to talk to a partner about HIV status based on the expectation for disclosing intimacy, this experience also emphasises the importance of openness in Raul's projected future with him. Suspecting that he might not be accepting of his status led him question whether it was worth continuing to develop their relationship. Raul's imagining of his partner's likely reaction and his appraisal of the value of their relationship in this light further

also highlights not only the complex emotion work involved but the reflexive nature of revealing a positive HIV status: not only the disclosure itself but an anticipated reaction to it influence when and how it might be explored by HIV positive participants. In these excerpts we see how, due to society placing normative value on a negative HIV status, simply having a positive HIV status in a serodiscordant relationship can entail additional emotion work, which can potentially disrupt the formation of lasting relationships. Although serodiscordant relationships are not sites of tension and difficulty, as the data in the rest of this study attests, external pressures of stigma and normativity can be disruptive.

In deciding when to disclose, Ben (48, HIV positive) described it as a risk calculus - weighing the risk of revealing a positive status too early, which might scare off a partner who had not yet developed an emotional bond, against delaying it, which if left too long could be perceived as a betrayal of trust. Thus, both saying something and not saying anything carried risks that could jeopardise the continuation of the relationship. He recognised this double bind as an intractable problem, but one that must be faced eventually. Acceptance of the inevitability of this potentially unpleasant and disruptive event and a desire to avoid prolonging uncertainty and to 'get things over with' led him to disclose earlier in the course of a relationship: *I wouldn't usually tell people up-front, although I've evolved now so that I sort of do, because I'd rather sort of... it took a long time, but I've reached the point now where I feel able to sort of do that and... prefer to.* To feel able to do so was not easy and took time and effort - being able to be open was hard-won through a personal journey towards empowering himself to be able to overcome his own concerns, indeed not only overcome them but to begin to change his whole approach to the issue. But despite his confidence in this 'evolved' approach, his partner still reacted negatively to the news when he told him at the beginning of their relationship.

Erm. But I told [partner] after a fortnight, or maybe three weeks? And

he was... a bit thrown because, he hadn't been out that long and he hadn't been through that particular experience. And I think I caught him off guard slightly. And er, his first reaction was one of slight anger... 'you know, you should have told me.' Fair enough. Oh well

Ben (48, HIV positive)

In his evaluation of the situation as '*Fair enough. Oh well*' Ben's dismay at his partner's initial angry reaction is evident, alongside a resignation that it is acceptable and an acceptance that Ben bears some responsibility for provoking the reaction. This layered response to how his disclosure was received brings to light the complex emotion work Ben carried out to navigate the situation and highlights how the process of disclosure is more than an event of simply 'telling'. An angry reaction, of feeling betrayed was also among the reactions of HIV negative men in Konda's study; a positive HIV status is seen as such a significant threat to the negative partner's safety that not mentioning it immediately becomes a dishonest omission (Konda, Sandoval and Najarro, 2017). This attitude towards disclosure has been described more generally in HIV negative gay and bisexual men who perceive themselves to be distant from HIV (Keogh, 2008b). Ben's partner's relative inexperience with life as a gay man is consistent with his unfamiliarity with the virus and, consequently, his shock at the news. Nick's experience of his partner telling him about his status shows how unfamiliarity with HIV played a role in his initial reaction, but also how he came to recognise and appreciate the vulnerable position his partner had put himself in by raising the issue.

When me and [partner] first got together, we always played safe, like because he didn't tell me he was HIV positive until our fourth meet. And I was a bit like... hmm. Because I hate to admit it, but back then I was ignorant and had no idea what undetectable meant. And I was going to be like, 'yeah, we're not going to see each other again.' But I spoke to other people and they were like, 'telling someone you're HIV positive is a really big thing.' And so I was like, OK, I should give

him a second chance

Nick (32, HIV negative)

Nick's experience also brings to the fore the important role that people outside a relationship can play in its formation and continuation: possibly without their intervention Nick would not have developed his more empathetic understanding of his partner's disclosure. It is interesting to note that although Nick credits his lack of familiarity with HIV and the idea of undetectability with his initial reticence to be with an HIV positive partner, it was a recognition of how difficult it must have been for his partner to tell him his status – and what this implied about how he felt about their relationship – that led Nick to consider continuing. As well as the important role of emotion in sustaining the nascent relationship, Nick's account also further reinforces the boundary work that many participants engaged in, delineating those 'in the know' from those who were 'ignorant' of the realities of HIV in the era of TasP.

Other participants found other ways to navigate and work around the challenges of disclosure. Charles (41, HIV positive) made use of gay dating apps which provided space to include HIV status on a profile to indirectly disclose to potential partners and pre-empt a face-to-face discussion.

*Well I had it on my Grindr and Scruff apps. Because it's just easier.
And I think sometimes people didn't see it. I know that some people
just didn't message me, so it's almost like taking away discrimination
because... there's a lot of reasons why someone might not message
you, but you don't even have to go there. You just get fewer
messages*

Charles (41, HIV positive)

By making himself available to serosorting by HIV negative men who would react badly to someone with a positive status, he made the process of it invisible to him. In taking an active decision to be open, he passively accepted and took as read the rejections that he would never see. Social media has in some cases

facilitated a pre-emptive disclosure of HIV status, transforming the experience of serodiscordancy and Race (2018) has examined the influence of increasingly digitally mediated interactions on shaping norms and expectations of HIV status discussion and disclosure and how individuals navigate and incorporate these new opportunities into their sexual and dating practices. Here Charles made use of an opportunity to share his status provided by a digital platform to invisibilise discrimination by making it a form of rejection experienced by all users of these social media apps, a lack of messages or replies. Using digital technology in this way shifted the moment of disclosure to before an initial meeting, effectively making it an emotional-labour saving device. As well as functioning this way, social media have also intervened in discourses of disclosure by establishing digital communities with different social norms around HIV status, as I will outline later in this chapter in *Managing a Serodiscordant Identity*.

The emotion work of being disclosed to

As well as the emotion work positive participants engaged in around deciding where and when to talk about their status at the beginning of their serodiscordancy, negative participants also discussed how they managed the emotions that hearing their partner's status raised. Thom had been in a relationship with his partner for 15 years when his partner was diagnosed with HIV. He described how he felt disappointment in his partner's becoming positive. Recognising that this emotional reaction was not supportive of his partner, Thom initially hesitated to express his feelings, but their strength was such that he had to give voice to them.

Well I did said to him, 'I'll say this to you once and then I'm going to move on from this, I'd say you were a fucking idiot and then I will never say that to you again.' Because if I hadn't ever said it, I'd have just kept it in

Thom (46, HIV negative)

By berating his partner for behaving idiotically, Thom implies that his diagnosis was a result of misjudged behaviour, of having made a mistake. Becoming HIV positive was an event so significant for his understanding of his partner that Thom sought to provide an explanation for how it occurred. He felt that it rested on his partner becoming depressed after his father died earlier that year: *'he thought, I don't care. Not that he thought he would for a second catch HIV, but he, you know, he was more reckless.'* This psychological account harks back to studies examining traits associated with condomless sex, locating the explanation for behaviour in an individual's personality (e.g., Israel, Romeis and Spitz, 2005). This is complicated by Thom's involvement in events; he introduced his partner to the man who was implicated in transmitting the virus to his partner, with whom he'd also had a sexual relationship. On top of his anger at his partner's behaviour, Thom also felt responsibility mixed with relief that he'd not become positive himself. *'If I'd never introduced them, would it ever have happened? So you know. There's that. Relief that it wasn't me... and frustrated that I couldn't have done anything about it.'* The interplay of emotions and different potential explanations around Thom's partner becoming positive shows how complex the experience of navigating a newly discovered serodiscordancy can be, particularly in the context of a long-standing relationship where partners might expect to 'know' each other more deeply.

Negative participants who learned of their partner's status early in their relationship also talked about emotion work that they engaged in in order to understand and engage with the idea of a serodiscordant relationship. When Phillip's partner told him about his HIV status on their first meeting after chatting on-line for several months, Phillip also reacted with disappointment. Yet this disappointment was not only less intense than Thom's angry reaction, but its focus was the disappointment of discovering the idealised image he held of his partner did not hold true.

I guess my initial emotion was... disappointment. Yeah. He's not perfect. You kind of hope [for] your knight in shining armour and all that kind of stuff

Phillip (51, HIV negative)

Seeing an HIV diagnosis as an imperfection is associated with stigmatised views of people living with the virus as 'less than'. Phillip described going through a process of adjusting his expectations. He recognised that romanticised standards he was judging the situation against, '*that ideology of meeting somebody, falling in love, being married forever and that would be it*' were unrealistic. In placing his partner's HIV status in this context, he is allying it less with a stigmatised identity and more as part of a recognition that no-one is in fact perfect, that it is simply part of the 'messiness' of life and part of a process of coming to know each other more deeply.

As well as managing their initial emotional reactions, some HIV negative participants described a reflexive engagement with those emotions, which further complicated how they responded to hearing about their partner's status. Although sadness could be understood as an empathetic reaction to hearing the news that someone has been diagnosed with a chronic health condition, Drew felt ashamed of his initial reaction due to his association of it with stigmatising discourses of HIV.

Um, I think I possibly wrongly felt a bit sad about it. Which was a stigmatising response there. I don't think I've even told him I felt sad to be honest [...] I guess I had that – and this is a problematic thought – 'oh so young that's a shame.' And that's a really problematic thing to think and I'm quite ashamed of thinking that, but it is where my mind went at that moment

Drew (23, HIV negative)

In his self-censoring, Drew's silence recalls the practices of other negative partners in serodiscordant relationships, who deliberately exclude talk of HIV in

order to avoid upsetting their partner (Persson, 2008). Drew's self-censuring reaction also brings to light a discontinuity in how notions of stigma relating to HIV have transformed through the biomedical. Normalising discourses of HIV have equated it with other long-term conditions. But, because of the stigma associated with HIV/AIDS in the past, an emotional reaction that recognises the impact HIV can have can itself become stigmatising. The emotions participants experienced when confronted with news of a partner's positive HIV status, although often fleeting, are suggestive of a reflexive expression of beliefs about HIV associated with older narratives about the virus and those living with it. In the case of these HIV negative participants, rather than self-stigma these experiences are followed by an awareness of their stigmatising potential and an effort to manage them in order not to express that stigma and upset their partner. This also shows similarity to those of people receiving a diagnosis in the era of 'normalised' medical discourse (Walker, 2019). Whereas Goffman's account of stigma places it firmly in the context of a social encounter (Goffman, 1963), these accounts highlight the dynamic nature of stigma, its complication by narratives of normalisation and how it engages with emotion work in a relational setting. They also question the presumption of U=U that stigma can be addressed through knowledge of TasP alone. Even in situations where participants were aware of TasP and of narratives of the normalisation of HIV, stigma about HIV persisted, albeit fleetingly and unexpressed. The complexity and messiness of these accounts suggests the need for nuanced and context-based understandings of how stigma operates in serodiscordancy, rather than a presumption of its absence. It also points to the way in which the personal and the social are brought together in intimacy and the complex way in which subjectivities are patterned through the social and the biomedical.

Disclosure as deepening intimacy

So far this chapter has examined some of the emotions associated with first

experiences of serodiscordancy, many of which have been, or had elements of, negativity. Here, I turn to instances where confronting serodiscordancy was not primarily negative but had positive connotations and was associated with acceptance and a sense of deepening intimacy.

For some, participants the experience was a turning point in their intimacy which cemented the future relationship. Matt (45, HIV negative) was aware of the expected response to learning that his partner was HIV positive but his instinctive response was to feel stronger emotions towards his partner. *'When he told me that he was HIV positive, you know, for me, I fall in love. [...] Instead of [laughs] telling you you're an asshole, or whatever.'* Having initially decided not to tell his partner about his status because of the way he talked about HIV, Raul found the way that he responded shed light on aspects of his personality he had not previously seen. In this transformed view of his partner, he felt a desire for a more profound connection with him.

That whole experience really changed my understanding and my perception of him as a person. And I could see that he had values and ethics that I didn't know he had before. And I was very suddenly attracted to him and it was a bit of a game changer in a way

Raul (34, HIV positive)

Although he had previously judged that his partner held negative views about HIV, and therefore had judged that a deeper relationship was probably not viable, being open about his status brought to light his partner's personal ethics in a way which he had not seen before. Raul found that this insight into his partner's moral make-up led to deeper feelings of intimacy transformed the way he viewed their developing relationship and its long-term prospects. Raul's account speaks to the role of 'deep knowing' in forming intimate relationships, in revealing intimate information about himself, Raul was able to understand his partner in this more profound way led to a strengthening of their relationship. However, positioning HIV status as critical to 'deep knowing' sits uncomfortably

with other participant's portrayal of it as an unremarkable aspect of their partner. This tension, between normality and exceptionality motivates many of the practices and the work undertaken by participants in 'doing serodiscordancy.'

When Peter discovered his status during an existing relationship, he felt that it would be a trigger for his partner to leave him and even suggested this to him. In the event, his partner dismissed Peter's suggestion out of hand.

We were due to have our civil partnership a few months after I was diagnosed. And I remember saying to him, 'you don't have to go through with it because do you really want to tie yourself to somebody whose future is uncertain?' And [partner] in his usual way – he's very matter of fact – and he just said, 'don't be stupid, let's just get on with it'

Peter (58, HIV positive)

Rather than presenting a further analysis of the shifting power dynamic in this extract, here I would like to focus on the way in which serodiscordancy is constructed and reacted to. In Peter's narrative, it is expected to be, indeed is presented as, a threat to the future of a relationship, through its introduction of an uncertain health burden in the future for one of the partners. However, in dismissing Peter's suggestion, his partner is not disagreeing with his assessment that it has introduced a new uncertainty into their relationship, but that it does not matter. Peter's partner accepts the new reality associated with Peter's HIV status as part of their shared reality in the relationship. His acceptance the difference in their statuses and the uncertainty associated with HIV is not predicated on an understanding of TasP or other biomedicalised discourses of normalisation, but an acceptance of a life lived together day to day in the face of a whole range of unknowns. The unsentimental tone of his response belies a deep commitment to Peter and to their relationship.

Phillip (51, HIV negative) presented the doubts he held about being able to cope with his partner's recently revealed HIV status dissipating in the moment that

they saw each other the day after they first met. During the early stages of his relationship, HIV was a topic of discussion with understanding the risk of transmission – or, based on an understanding of TasP, the lack of it – was part of this process.

I can remember closing the door. And thinking am I ever going to see this guy again? And will it be too much for him to deal with, the difference... the discordance, will it be something that, do you know, what I'm going to phone him and say, no don't bother? And he turned up [the next day]. And I was just so pleased to see him that it just became evident that it really didn't matter. I think over that weekend, we talked about how we were going to manage it, what were the risks that were involved and all of that kind of stuff.

And just recognised that, actually, we wanted to give it a go

Phillip (51, HIV negative)

Philip's exploration of the viability of a serodiscordant relationship from both his and his partner's perspectives helps him construct a mutual acceptance, of serodiscordancy as a property of their relationship. In this aspect, it echoes Giddens's conception of the 'pure relationship' in which the only criteria which truly holds the relationship together is the mutual satisfaction of the partners in it. However, this particular relationship is founded on not only an understanding of the partners' willingness to enter into it, but also an agreement of the steps they would both take to prevent Philip from becoming HIV positive. The idea that serodiscordant relationships are founded on not only the desire of the partners to participate in them but also an agreement founded on biomedical prevention principles has been taken up by Philpot and colleagues (2018) who propose that partners in serodiscordant relationships formalise these agreements in Viral Load Agreements (or VLAs) in order to document and monitor these commitments to each other.

'Cocoons' and 'bubbles' – Managing a serodiscordant identity

Away from participants' first experiences of serodiscordancy that I have considered so far in this chapter, participants engaged in a related range of practices and work in relation to discussing issues of serodiscordancy and HIV status with others outside their relationship, including friends, family and co-workers. Participants often drew a contrast between their understanding of HIV and that of others, focusing on this as the root of potential stigma and leading to their engagement with the question on whether to discuss their serodiscordancy or not. Participants contrasted the lack of importance of serodiscordancy to them in their everyday lives and their comfort with the idea with the attitudes of others around them and the potential for stigma. Confronting the potential reaction of others brought to the fore that serodiscordancy is not 'the everyday' for everyone.

You sort of forget about it until you actually bring in these... complications. Well, these things that move you from your little safe little cocoon about how you've dealt with it, to oh [now] someone else has got to [be involved]... and then I think 'we've got to think about their bloody reaction now!'

Laurence (37, HIV negative)

Charles also recognised that the comfort he felt around his relationship within his immediate circle of friends did not mean that this was a universal truth. Although he lived in a world in which serodiscordancy, HIV and same-sex relationships were normal, these views were not held by everyone and were contingent on a particular set of social and political circumstances.

The fact you're doing research about this, part of me feels like well it's not an issue anymore. But, I know for a fact it is. And we're in this little bubble in time, and a bubble in social attitudes which could

change. And it's certainly not like this in many, many other places

Charles (41, HIV positive)

Charles highlights the importance of social attitudes in him feeling comfortable talking about serodiscordancy, which aligns with the experience of participants in Konda's (2017) study of gay men in serodiscordant relationships in Peru. Widespread homophobia meant that many participants were not open about their sexuality, or being in a relationship. This, as well as a desire to maintain secrecy around their serodiscordancy, led to higher levels of stress among participants. Another sociocultural factor that influenced participants practices around disclosing their serodiscordancy was the normative position of a negative HIV status. Based on this fact, participants' discussions of serodiscordancy often focused on managing disclosure of the positive partner's status. This was something that was, in line with the experiences outlined around disclosure at the start of a relationship, a personal decision for the HIV positive partner and one that needed to be carefully considered and managed, based on an expectation of the implications of the disclosure. Similar to the findings of the Positive Voices survey, participants were more often open with close friends about their status, but had not told their family (Kall et al., 2020). In some cases, participants had decided not to tell their family in order to avoid causing distress to their relatives who may have held out-dated views of HIV, as Raul explained:

I haven't told her about my status. And it's something that I wouldn't want to discuss with her or disclose to her. Nor to any of my relatives for now. Just because she's so... she tends to make a big deal out of small issues. And this in particular, this is an issue I know that worries her. So I wouldn't want to [tell her], I know that she would really worry about it. And I don't think I need that

Raul (34, HIV positive)

As well as avoiding causing his mother distress for her own sake, not telling her about his status also meant he would not have to deal with his mother's distress.

This practice of silence is made easier by Raul's presentation of his status as a 'small issue,' rather than a significant omission with implications for a lack of honesty between him and his mother. Raul's selective openness with his mother echoes Jamieson's (1998) analysis of intimacy between parents and children: although openness and honesty are positioned as an important part of the relationship, in practice children engage critically and selectively with disclosing intimacy, which can slip from knowing each other to parental surveillance and control through knowledge (Solomon, Warin and Lewis, 2002), this is particularly true for 'sensitive' subjects of sexuality (Gabb, 2008, p. 75). Raul's decision not to be open with his family about his status runs contrary to the demands of disclosing intimacy and introduces the idea that by concealing important information about himself and his relationship, the relationship with his mother is less close. Yet alternative views of secrecy, concealment and silence show the social function that such 'deceptions' can serve (Scott, 2012). Furthermore, conceiving of his actions as 'protective opacity' (Appignanesi, 2011) highlights how Raul's decision considers his mother's feelings and could be understood as an act of respect (Gabb and Fink, 2015a). This further highlights the complexity of the emotion work inherent in managing an HIV positive (and serodiscordant) identity and further supports the conception of this process as an emotional, relational process over more instrumental accounts of it as a 'health behaviour' (Flowers and Davis, 2013). Tom's experience of discussing his status with his grandmother also highlights the role of intra-family relationships and how, as with Raul, expectations of a person's reactions can influence decisions to discuss HIV status.

I remember telling my grandma. And her first, her initial response was, 'oh yeah I saw a BBC documentary about that, I know it's not the end of the world anymore.' Even though all of the rest of my family were like, 'don't tell granny, don't tell granny...' and I've always told them they underestimate her. Like when I came out when I was 16 to her, she was fine as well

With serodiscordancy tied so closely to the positive partner's status, negative participants rarely discussed it themselves, as this would imply a breach of confidence. In discussing PrEP and HIV prevention, Brian realised that he had revealed his partner's status, which he recognised as a transgression of good practice. He and his partner had an open relationship and had agreed that when chatting on-line to potential threesome partners, Brian was able to discuss their serodiscordancy as part of a wider discussion of approaches to sexual practices. However in the non-sexual context of his workplace, disclosure took on a different meaning.

A couple of women [at work] asked what PrEP was. And I was explaining it to them. And I realised as I was going through the explanation [that] I had basically disclosed [that] I was negative and [partner] was positive without even thinking about it. When I spoke to [partner] about that, I said, I realised I've kind of disclosed that. And I think he was a bit... he wasn't angered, he was 'yeah, if it's a non-sexual disclosure, I'd rather you discussed it with me before you disclosed it'. I said, well... I appreciate that. The people I work with, you are never going to know them, never going to see them, but I appreciate that was wrong of me

Brian (41, HIV negative)

In consideration of telling others about being in a serodiscordant relationship, normative views of HIV negativity, disrupt the dyadic nature of serodiscordancy and focus on the HIV positive partner alone. Managing this asymmetry led Brian to be expected to practice silence regarding his relationship in order to protect his partners' status. This silence was not universal and in defining those to whom it would be permissible to discuss his partner's status, based on the potential for a casual sexual relationship, Brian and his partner were undertaking boundary work as part of these practices of telling and not telling. Gary engaged in boundary work through his selective engagement with the prerogative of people

living with HIV to educate others about the reality of living with the virus and TasP (see *Asymmetry of responsibility*). For potential sexual partners he met via social media apps, he practiced disengagement rather than engagement and education, as he might with those he had a pre-existing relationship with. Maintaining a boundary between those he would educate and bring into closer intimacy and the 'ignorant' he could dismiss helped him to be selective and manage the work of deeper disclosure.

If it was somebody that I knew saying it, or somebody that had some actual relevance in my life saying it, I might be concerned. But if it's a random person that genuinely I don't know, I'm able to brush it off because it's ignorant and ill-informed and [they] just need to go away and read some stuff

Gary (40, HIV positive)

Patrick's partner also maintained a boundary between those he discussed his status with and those he would not. He recognised and supported his partner's boundary work around managing his identity in this way but, in contrast with Brian and his partner, positioned it as solely his partner's to manage and maintain.

His family is aware and our friends are aware of his HIV status, but he doesn't... he certainly doesn't wear it on a T-shirt. I'm quite proud that he has a very honest approach to all of that with these closer friends that we have. And with his family. But I also appreciate that he doesn't want everyone to know. Certainly with work and with travel concerns, for instance

Patrick (43, HIV negative)

As these examples have illustrated, the practices of managing serodiscordant identity focused on maintaining boundaries around (non)disclosure of a positive HIV status. As such, they were positioned as the responsibility of positive partners by negative participants. Managing and maintaining this division of

labour was associated with emotion work. Although Sean was comfortable with the idea that his partner was uninfected sexually, he was unsure what the implications of his partner injuring himself while playing sport would be.

[Partner] had fallen and cut himself quite badly and was bleeding quite a lot. There was just something at the back of my mind going: 'oh God. Is he going to have to disclose?'

Sean (33, HIV negative)

Sean's primary concern was not around his partner's injury or the potential for transmission that his blood presented, but around whether he in relation to whether the injury would necessitate him revealing his status. Thom (46, HIV negative) also imagined catastrophic scenarios in which his partner was hurt and unconscious, *'I worry about... in what circumstances would I have to disclose his status, when he's not aware.'* Bearing the sole responsibility of disclosure and being obligated to break his partner's confidence was for Thom, *'the worst thing that could happen.'* Despite the dyadic nature of serodiscordancy, questions of who and when to discuss difference in HIV status were firmly rooted in the normativity of an HIV negative status and practices of identity management and boundary work were the responsibility of HIV positive partners. Situations that threatened to upset this 'division of labour' were experienced - or imagined - by negative participants as potential moments of crisis.

In other instances sociocultural conceptions of HIV as a highly virulent infection led to a reversal of the normativity of a negative HIV status: learning of someone's positive status immediately called into question their partner's. This inversion led to situations where revealing a negative status became important (see *Deploying serodiscordancy as advocacy*, below). But this was only the case in some circumstances. Nathan did not routinely reveal his negative status to those who knew his partner was positive and wondered whether normative assumptions about negative status held true, whether others assumed he was positive or if it was simply too direct a question to be politely asked.

No-one has ever asked me. I don't know if anyone's ever been brave enough to ask that question. I just assumed that if I was positive, that they would know. But not one person has ever asked me my status [...] And I haven't actually gone out and broadcast it either: 'So by the way I'm not...' I don't really know really if they've ever wanted to ask and just never felt they could ask?

Nathan (55, HIV negative)

Charles equated the lack of need to discuss in his partner's status as predicated on the fact that it was not relevant to other people, based both on his undetectability and the self-contained nature of their relationship. He suggested that because they were self-sufficiently managing their serodiscordancy between themselves it was therefore neither relevant nor important to others.

I haven't ever found myself sort of explaining, oh this is [partner] and he's negative. It's like we're in a world that's past caring. As long as you're not dangerous to anyone and as long as you're managing it, then there are bigger things to worry about

Charles (41, HIV positive)

In presenting his relationship as a self-contained dyad of little interest and relevance to the wider world, Charles is drawing on a view of relationships existing in a vacuum, of relevance primarily only to those participating in them that underpins Gidden's account of 'pure relationships'. This conception makes primary the intimacy between the partners and views them as if in a vacuum. An alternative conception of intimacy emphasises the relationship between not only immediate partners but also others. In a study of long-term relationships, participants emphasised the importance of intimate others, friends and family, in supporting and sustaining couple intimacy (Gabb and Fink, 2015a), a sentiment echoed by Cliff.

Yeah, I couldn't function in a relationship if I didn't have my friends, I don't think. So I have to have that out there, have different people

*to talk to and, not necessarily about the relationship, although I
might do, because I'm quite transparent on that front*
Cliff (51, HIV negative)

Recognising the importance of others in sustaining his relationship intimacy with his partner, Cliff also acknowledges raising relationship intimacy with friends is potentially complicated, yet in doing so without referencing serodiscordancy *per se*, he makes an implicit assertion that serodiscordancy is not the defining feature of the relationship with his partner, nor is it an issue that demands discussion or, on the other hand, silence.

Deploying serodiscordancy as advocacy

One exception to the general rule of silence around serodiscordancy and the boundary work of bringing others into or excluding them from greater intimacy related to occasions where participants judged that the existence of their serodiscordant relationship could function as a way to educate friends, or the general public and, in doing so, counteract HIV stigma. Justin used his partner's sustained negative status as a way to tackle assumptions about the virulence of HIV and the possibility of a long-term intimate relationship without HIV transmission.

*If I were talking to somebody who was doubtful about the non-
infectiousness of a suppressed person, I would tell them that [partner]
was negative after 20 years. We have always used condoms for anal
sex. But even so, a lot of people would think you're almost certain to
get HIV if you lived in the same house*

Justin (76, HIV positive)

Even though Justin and his partner continued to use condoms in their sexual practices, and as such did not fully embrace the promise of TasP, for him this did not detract from the importance of making people aware of the *possibility* of

sustained serodiscordancy. By focusing on his partner's (normative) negative status, Justin is also suggesting that their relationship is in some sense normative as well. Although because of this normativity, disclosing a negative status is associated with less emotion work than disclosing a positive one, some negative participants also used their partner's status to highlight stigmatising attitudes or behaviours in their friends. Although Brian and his partner had agreed that Brian was able to disclose his partner's status to potential sexual partners in the context of their open relationship, the anger he felt when he learned of a close friend's behaviour towards someone else living with HIV led him to disclose his partner's status.

My best friend and I are entirely non-sexual and so it was never an option that he would kind of need to know, so never even thought to tell him. And then he did something which pissed me off quite a lot, he dumped someone for being positive [...] I thought that's just wrong. It really annoyed me. So [friend] and I fell out a bit over that and that's when I disclosed about [partner's] status

Brian (41, HIV negative)

As with Justin's discussion, although Brian's disclosure focused on his partner's positive status, it was his continued negative status which conferred normativity on their relationship. Furthermore, in the face of his friend's prejudice against someone else living with the virus, Brian's emphasis on his partner's status became a defiant rejection of the stigma his friend had invoked. This use of serodiscordancy to highlight and confront stigma echoes the challenge of U=U voiced by Anthony Fauci that HIV was *nothing to worry about*. Brian's defiant response to his friend and U=U's challenge corresponds to Goffman's framework of responses to stigma that he describes as 'obstinately attempt[ing] to employ an unconventional interpretation of the character of his social identity' (Goffman, 1963, p. 10). Other participants employed this, albeit in a less emotionally intense setting, when they gave public presentations about their experience of being HIV positive, of which being in a serodiscordant relationship was

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sometimes a part.

For example [in] talks [arranged by an HIV charity] I will say that we are a magnetic, I prefer magnetic rather sero... we are a magnetic couple. People will ask about... 'so how does that work?' And that kind of thing. If I'm speaking just as me, then [partner] isn't necessarily part of that discussion. If people ask, then I'll say he's negative

Peter (58, HIV positive)

That Peter, when speaking 'just as me' does not necessarily speak about his partner's status unless asked, highlights the way in which a serodiscordant identity is subsumed within – and sometimes obscured by – considerations of individual serostatus. A biomedical conception of 'living with the virus' which locates it within an individual body supports this approach over a more distributed, community or sociological lens in which 'living with' is a property of the dyad. While 'doing serodiscordancy' in this context provides opportunities for both HIV positive and HIV negative participants to draw on their experiences to challenge stigma, I have argued that these practices are inflected through sociocultural norms and, as such, are unable to 'bridge the serodivide' (Persson, Ellard and Newman, 2016). By making visible the existence of serodiscordant relationships, these practices not only confront and respond to HIV stigma but also, play part in the social processes of normalisation that Plummer describes as 'telling sexual stories' (1995).

Summary

This chapter has examined participants' first encounters with serodiscordancy and how they later managed their identity as a serodiscordant couple with others. It has outlined the emotion work that participants engaged in when managing their serodiscordant identity and argued that the way in which participants routinely managed their serodiscordant identity drew strongly on

the social norm of HIV negativity, and in doing so focused primarily on the HIV positive partner managing their identity. It has also considered the way in which some participants chose to use their relationships as an opportunity to manage HIV stigma for themselves and more broadly.

For many HIV positive participants, the experience of beginning a serodiscordant relationship included making decisions about when and how to reveal intimate information about themselves to their partners. Biomedical and pharmaceutical developments underpin this decision, locating and revealing the virus in an individual through antibody testing and simultaneously concealing its presence by preventing the onset of visible symptoms. The emergence of pharmaceutically mediated mitigation of transmissions further complicates the process (Lampe *et al.*, 2012; Daskalopoulou *et al.*, 2020). Nevertheless, a biomedical division of labour in combination with community ethical norms which place the preservation of someone's HIV negative status above other considerations (Davis and Flowers, 2011) mean that the obligation of HIV positive individuals to disclose continued to be felt by participants. Viewed through the lens of relationship intimacy, the decision to 'come out' about HIV takes on a further weight as deep knowing and self-disclosure distinguish meaningful relationships from casual sexual encounters. This supports 'deep knowing' (Giddens, 1993; Jamieson, 1998) as an important part of an intimate relationship and simultaneously cements serostatus as an intimate part of someone's identity: without knowledge of their status, a partner could not be said to truly 'know' them. These reinforce ideas that HIV is a defining feature of an individual (Flowers and Davis, 2013; Persson, 2013a), even as TasP and U=U argue that status has less relevance to intimacy. Despite these motivators of disclosure, HIV positive participants engaged critically and reflexively with the decision on when and how to tell their partner about their status, conscious of previous negative experiences and re-confronting self-stigmatising attitudes. For HIV negative participants, learning their partner lives with HIV was sometimes a

moment of shock, but also provided new ways to practice care for their partner and adopt different discourses of HIV. Some common narratives around serodiscordancy in a post-TasP world are emerging (Persson 2016). The ethical and moral discourses which favour disclosure of an HIV positive status also provide a framework for how negative partners receive the news that their partner has a long-term health condition, favouring self-education and acting to relieve any potential burden of stigma relating to the disclosure. These data also show how the introduction of HIV into an existing relationship can transform intimacy, providing both new opportunities for partners to express care and support for each other and, on the other hand, emphasising growing distance and providing ammunition in arguments. Both positive and negative participants engaged in emotion work around becoming serodiscordant. In these narratives of the beginnings of serodiscordancy, there sense that there was a coming-to-terms with the virus in the relationship which needed to have taken place before achieving a state of acceptance, of 'living together with' – that things are different now to the beginning, that the work – of disclosure, of overcoming fear, of adjustment, of discussion and agreement about the importance of HIV in the relationship – has been achieved. In analysing these experiences, focusing on a before and an after serodiscordancy was first encountered constructs them as 'events' – creating a difference that defines and is defined by those involved (Fraser, 2010 in Race, 2018). Focusing solely on these fateful moments (Giddens, 1991) risks construing these relationships as static and ignores ongoing dialogue with the intimate and biomedical. Fateful moments stand in contrast to the everyday in which meanings are made (Gabb and Fink, 2015a) and I have argued that the accounts presented here suggest the way in which 'ordinary moments' instead make up the substance of these processes.

Many of the practices and the work undertaken by participants in managing their identity were motivated by a tension between normalised discourses of HIV and wider sociocultural norms that privilege HIV negativity and, in doing so,

stigmatise an HIV positive status. The emotion work that negative participants (who were aware of TasP) engaged in relating to their feelings about their partner's status highlights the complexity of the processes operating around stigma and suggests the need for a nuanced, contextual understanding of how it is navigated. This stands in contrast with the simple rhetoric of U=U in which knowledge of TasP leads to the dissolution of HIV stigma. Despite this in managing a serodiscordant identity in the context of HIV negative as normal, participants engaged in boundary work to identify and 'bring in' some through engagement with TasP and U=U, and to either actively disengage from or maintain silence around others. In addition to the emotion work of participants, I have reflected on how the interplay between 'normality' and stigma in the context of TasP also influenced the way in which I advertised this research and conducted interviews (see Appendix G). The interplay of the private and the public in these accounts demonstrates the complex way in which intimacy is patterned and structured by the social and, in the case of serodiscordancy, by the biomedical as well (Plummer, 2003).

8. Conclusion

*I am concerned with how our most intimate decisions are shaped by
(and in turn shape) our most public institutions: how the public may
become more personal and the personal more public
Ken Plummer, Intimate Citizenship, 2003*

'Would you tell me, please, which way I ought to go from here?'
'That depends a good deal on where you want to get to,'
said the Cat
Lewis Carroll, Alice's Adventures in Wonderland, 1865

Thus far, I have focused on 'doing serodiscordancy' as a lens through which to examine the practices and work through which participants make meaning and how those meanings have been shaped by the biomedical and the social. As I outlined in Chapter 1, I have 'bracketed' what these meanings imply for ongoing debates relating to the broader meaning of serodiscordancy in the context of biomedicalised HIV prevention. Drawing on Plummer's theories of intimate citizenship and the role that the intimate can play in processes of social transformation (Plummer, 1995, 2003), I will consider how the experiences of serodiscordancy examined in this research can inform health promotion and HIV prevention. In this final chapter, I will summarise the work and practices of 'doing serodiscordancy' explored in Chapters 5, 6 and 7 and draw connections and commonalities between these findings. In the last section of this chapter, I will move from examining 'doing serodiscordancy' as a phenomenon in its own right to considering how these findings could inform further research, on serodiscordancy and beyond. I will also explore some of the implications of my research for people in serodiscordant relationships and the practice of healthcare professionals involved in the management of people living with HIV as well as some reflections on what this means for the U=U movement and its objectives.

This thesis has focussed a sociological lens on the lived experience of serodiscordancy for a sample of gay and bisexual men living in the UK. In the data analysis chapters I have described how participants in this study engaged with biomedical conceptualisations of the transformation of HIV in the everyday. In particular, I have focused on how they navigated relationship intimacy to create a sense of normality around serodiscordancy in their everyday lives and in their sexual intimacy. I have shown how this was inflected through multiple discourses around different ways of doing same-sex relationships, ageing as a couple, and public health discourses of sexual safety. I have highlighted the everyday practices of intimacy and emotional labour which sustain a sense of normality and the everyday absence of HIV, and which together constitute what I have termed 'doing serodiscordancy.' In addition, I have also focused on the limitations of these practices in resisting broader social and historical conceptions of HIV (and serodiscordancy) as troubling and the enduring asymmetries of serodiscordancy. Just as the antiretroviral drugs made HIV undetectable in the positive partner's blood, 'doing serodiscordancy' enabled participants to practice their relationship in the 'absence' of HIV.

Practices of serodiscordancy

This section examines the intimate practices which participants used in the everyday to support and express their closeness and specialness to each other whether this was in the everyday, in the bedroom or how they brought others in closer to their relationship (or not) through practices of telling or of silence. Bringing these practices together under one heading underlines the way in which 'doing serodiscordancy' is constructed in lived experience through a range of everyday acts which considered individually may not necessarily mean much but considered together help to trace the influence of the biomedical and broader social attitudes on participants' lived experience.

Everyday practices of serodiscordancy

Due in part to the current UK medical policy of treating everyone who is HIV positive, participants current experiences of serodiscordancy were closely bound up with experiences of HIV treatment. As outlined in Chapter 5, the pills, the daily act of consuming them and the accessories associated with this process, such as pill bottles or divided pill boxes were a material presence in participants' relationships and formed the basis of a range of relationship practices. Supportive practices performed by negative partners, such as verbal reminders to take treatment, were most often framed by both positive and negative participants as forms of caring. These practices were also focused on the way in which treatment protected the positive partner's health. While this was the dominant meaning attributed to these acts, one HIV negative participant acknowledged that there were occasions when his 'checking' did take on an element of surveillance, confirming that his partner was adherent to treatment and therefore likely to maintain his undetectable status. These practices played the role of thoughtful gestures, performed irregularly or at certain times such as holidays, rather than the daily activity demanded of positive partners. Through these practices, negative partners could participate in the daily work of HIV management, even though remaining undetectable remained firmly the positive partner's responsibility. Positive partners sometimes framed their medication consumption as not only for their own health, but also as a way in which they could protect their partner and spare them having to consume their own antiretrovirals in the form of PrEP. In these ways, treatment became part of the 'affective economy' (Gabb and Fink, 2015a) of a serodiscordant relationship. Where other couples demonstrate care through thoughtful gestures or practical acts, participants in serodiscordant relationships used these practices to demonstrate and reinforce their care for each other's health and, by extension, each other.

The routine nature of taking treatment led many participants, both positive and negative, to portray it in terms of daily practices of hygiene or domestic chores – taken for granted and unremarkable. Although the only visible daily impact of serodiscordancy on the everyday was ‘just taking the pills’ this focus on the material elided the emotional dimension that taking treatment sometimes took on. Rhetorically diminishing the importance of treatment also minimised the impact of the side effects of treatment that were experienced by many HIV positive participants. In addition, some HIV negative participants held suspicions that these ‘powerful drugs’ that held the virus at bay may have also had pernicious effects, affecting the positive partner’s memory or moods.

In addition to the daily practice of treatment, ‘doing serodiscordancy’ was also organised around regular biomedical monitoring of the positive partner’s viral load, providing continued confirmation of his undetectable status. For participants diagnosed recently, achieving and maintaining an undetectable status was occasion for a moment of celebration or achievement. But once an undetectable viral load became a stable and consistent, receiving confirmation of their or their partner’s viral load from the clinic became a routine and unremarkable event. Although some of the practices, such as reminders, outlined above allowed negative partners to play some part in the daily management of HIV, the ongoing monitoring of viral load remained the domain of the positive partner. This was often based on practicalities of having to attend appointments at hospital and the individualised delivery of HIV services in the UK. This was sometimes questioned by expectations from others outside the relationship that negative partners would take an active interest in care. In contrast, for many participants this autonomy around engagement with HIV medicine was understood as an expression of trust rather than being neglectful.

The idea of stability and continuity is at the foundation of this part of ‘doing serodiscordancy’. It is built up from the regular practices of taking tablets and of blood work. In this way, these findings echo those of Philpot’s study of

serodiscordant relationships (Philpot *et al.*, 2018), where repeated undetectable viral load tests and negative HIV tests led participants' sense of confidence in the concept of U=U. These biomedical practices are also embedded in a wider web of shared relationship routines and regular communication. A broader sense of 'deep knowing' (Jamieson, 1998) about their partner through all of these interactions, supported the perception among negative participants that their partner was working to sustain his own health and (through his undetectable status) their own. This trust, in both the reliability of their partner and in the efficacy of his medication, once established was durable even in the absence of confirmation of test results. In the majority of the situations described by participants, the involvement of negative partners in these practices was mostly superfluous. In situations where domestic routines were disrupted, such as around holidays, negative partners were able to play a role and could become an additional resource to draw on to support and sustain the daily practice of treatment. These findings echo other research on serodiscordancy which emphasize the centrality of trust, not just in each other, but in treatment and in healthcare providers, supports and sustains a shared sense of involvement in each other's lives and in a shared future (Newman, Persson and Ellard, 2017).

These practices highlight the centrality of the biomedical in 'doing serodiscordancy', as well as the way in which treatment was the bedrock not only of the ongoing health of the positive partner, but also the sense of stability and continuity in the relationship. Although I have highlighted ways in which the practice of treatment could take on different meanings for participants at different times, or was incorporated into everyday practices differently, there was consistency in the recognition of the fact that treatment was foundational to a serodiscordant relationship. This reflects the current UK context in which antiretroviral treatment is routinely started immediately after diagnosis; there is no question of whether someone should or should not be on treatment. Although participants in this study did not question whether or not treatment

was necessary in their current circumstances, some of those who had been diagnosed earlier in the epidemic had previously resisted starting treatment until the impact of the virus on their health led them to deem it absolutely necessary. This critical engagement with the need for treatment is echoed in other studies of community attitudes towards TasP, in which participants questioned the motives of pharmaceutical companies in supporting universal access to treatment and also highlighted the potential for people living with HIV to be compelled to take treatment for the benefit of others (Keogh, 2016; Young, Flowers and McDaid, 2016; Young *et al.*, 2019). These studies drew on data generated in focus groups, so emphasise social and political discourses, which contrast with the intimate and affective domain that my data are concerned with, which may explain the different engagement with the commercialisation and commoditisation of HIV treatment. This raises an important distinction: while intimate citizenship emphasises the way in which the private and public are linked, there are nevertheless differences in the discourses active in these domains.

Although treatment itself was unquestioningly a key part of participants' 'doing serodiscordancy' there were some tensions around the place of biomedical monitoring. One centred on the importance of HIV testing for the negative partner, revealing a conflict between the relational understanding of undetectability in preventing transmission and the importance of an individual knowing their own status through regular testing. A second tension arose in response to a move within UK HIV medicine to monitor stable patients less frequently. The importance of stability in achieving a sense of relationship safety highlighted above meant that some positive participants were reluctant to increase the interval between their regular blood tests and some had specifically requested more frequent monitoring for their peace of mind.

Sexual practices of serodiscordancy

Turning to the sexual practices of serodiscordancy outlined in Chapter 6, many participants focused on their use of condoms for anal sex with their partner. Many drew on TasP as 'permission not to use condoms' (Persson *et al.*, 2016), engaging in condomless sex with their partner. This practice intersected with practices associated with monogamous relationships, in which condoms were framed as unnecessary when partners were not exposed to the risk of sexually transmitted infections from others. The dual association of condoms with both protection from HIV and protection from 'unknowns' meant that for some participants there was a tension between wanting to retain them for HIV prevention but also their association with promiscuity and non-monogamy. As in other research (Goldenberg *et al.*, 2015; Grundy-Bowers, Hardy and McKeown, 2015), those not using condoms reported greater feelings of intimacy, of becoming conjoined, or of being able to take pleasure in the sensation of ejaculating inside, or being ejaculated in by, their partner. For others, undertaking a previously stigmatised and deviant practice also held its own pleasure. Although for many it was now part of their 'normal' sexual practice, deciding not to use condoms was framed by many as a joint decision and one which held important meanings for the seriousness of the relationship. It became a further way for negative partners to demonstrate their love and acceptance of their partner. This echoes the findings of studies conducted before the advent of TasP (Davis and Flowers, 2011). That this practice still holds emotional currency reflects the continued societal emphasis on a negative HIV status having greater value. In addition, in the era of TasP, condomless sex took on a new meaning for participants. Not using condoms was, for both partners, an 'act of faith' in TasP. It provided both a way in which they could enact their understanding of themselves or their partner as uninfected. In this way, for many participants practicing condomless sex became an integral part of their 'doing serodiscordancy'. Even for those not currently practicing condomless sex,

there was the more or less distant prospect of a future where they would not use condoms, tied both to an understanding of TasP and a willingness to embrace uncertainty and enact that understanding.

Corroborating other research (Persson *et al.*, 2016; Philpot *et al.*, 2018), despite TasP and U=U suggesting that condoms are no longer necessary in serodiscordant relationships, many participants continued to use condoms as part of their sexual practice. Those that continued to use them framed their practices in terms of HIV prevention, but the risks of 'other STIs' for those in open relationships also influenced their decision making. Other participants raised the role of habit in their practices: although they were aware that TasP meant that condoms were not necessary, they continued to use them. Some framed this in terms of a process of becoming comfortable with the idea, moving towards an imagined future in which they no longer used them. Some participants drew on pre-TasP risk reduction practices, such as seropositioning, deploying condoms for acts which they deemed higher risk. Although this approach was accepted by positive partners, continuing to use condoms embodied the idea that positive partners were still potentially infectious. As highlighted above, condomless sex also became a symbol of acceptance of TasP. Some HIV positive participants worked to persuade their partner that accepting condomless sex was an important part of fully accepting their identity as an undetectable HIV positive man. Others worked to accept their partner's desire to continue to use them, framing their partner's comfort as the most important factor. These practices also show how 'doing serodiscordancy' draws on biomedical risk reductions to recast previous sexual practices and identities in a new light, but, in line with Clarke and colleagues' characterisation of the process of biomedicalisation (Clarke *et al.*, 2003), it is not complete or evenly realised through and evidenced by people adapting their existing practices or continuing to draw on old ones. These data also demonstrate the way that care and affect inflect all engagements with the biomedical. Emotion work was associated with decisions around not using

condoms, but it was also associated with deciding to continue to use condoms. Again, turning to everyday 'ordinary moments' helps to highlight the way in which affect, practices and the biomedical are entangled in lived experience.

Practices of serodiscordancy to manage stigma

The practices relating to stigma management focused primarily on revealing or concealing an individual's status or on engaging in 'education' around the current biomedical reality of HIV and TasP. With an HIV positive status retaining its places as a 'discreditable identity' (Goffman, 1963), many participants engaged in 'reputation management' by concealing their, or their partner's, status from others they came into social contact with. The decision to discuss (or not discuss) serodiscordancy was most often framed in terms of revealing the positive partner's diagnosis. This reflects the normative value placed upon an HIV negative status. This was sometimes troubled by the 'myth' of HIV as such a virulent infection that serodiscordancy is unlikely. HIV negative participants were, therefore, sometimes 'outed' by their partners as not being positive. This was sometimes part of a move by HIV positive participants to 'educate' their friends, family or the general public about TasP and other times as a way to ensure that those finding out about the participant's positive status were clear that they did not also have to worry about their partner's status too. In this way, the relationality of serodiscordancy troubled the individualised, private nature of someone's HIV status and in some cases inverted norms of status disclosure. The normativity of a negative status made this kind of revelation less troubling than a negative participant revealing their partner's positive status. This still carried emotional significance and imagining that they might be obliged to disclose their partner's status in an emergency was a concern of some negative participants. I will further discuss the emotion work that participants engaged in around these practices in the next section. Thus both talking about, and not talking about serodiscordancy were strategies that participants adopted to

manage stigma. Discussion of serodiscordancy with potential sexual partners for participants in open relationships was a further setting in which practices of silence or disclosure were in tension. Many felt that despite TasP disclosure was still an important consideration, in line with the greater intimacy of a sexual encounter and a commitment to openness informed by ethical and legal imperatives. Others argued that the role of TasP in mitigating risk also mitigated the necessity of disclosure in some situations. Some participants drew on the emergence of other biomedical risk reduction technologies, such as PrEP, to draw an equivalence between being HIV positive and undetectable with being HIV negative and on PrEP in order to justify not being open about their HIV status with sexual partners. The lack of risk allowed them to frame themselves as responsible, while the casualness and relative anonymity of the encounter also absolved them from disclosure because of the lack of intimacy that it implied.

The analysis of these practices in this section illustrates how the biomedical, through TasP, acts as the foundation of many of the practices of 'doing serodiscordancy', from the material practice of daily treatment through sexual practices relating to condom use through to the discursive practices of concealment or disclosure of serodiscordancy in social situations. What it also reveals is how many of these practices have their roots in pre-TasP intimacy and how biomedical transformations lead to the evolution of existing practices to take on new roles and meanings or (as in the case of disclosure) are inverted, rather than being entirely replaced. Finally, this section also shows how although a key claim of 'doing serodiscordancy' is that HIV is 'undetectable' in everyday life, many of these practices reflect wider social norms and 'myths' of HIV.

The work of 'doing serodiscordancy'

This section turns from the practices described by participants to the way in which these practices, and the social norms that shape them, played a role in participants' emotional landscapes. In examining the ways in which participants sought to hold together sometimes dissonant discourses in the everyday, I will draw further attention to how wider attitudes towards HIV inflected and shaped participants' lived experience of serodiscordancy.

Everyday emotion work

The practices of 'doing serodiscordancy' sought to incorporate the phenomenon into the everyday. The emotional labour of 'doing serodiscordancy' served to rebalance and resist stigmatising societal discourses of HIV which impinged on participants' experiences in order to achieve the aim of 'HIV not mattering.' In many cases this labour was implied rather than explicit, glimpsed through asides in participants' accounts – '*bless him*' '*hey, it's fine*' - and hinting at a broader picture in which a positive HIV status was accorded lower value than a negative one. In this landscape, relationships between HIV positive and negative individuals are necessarily unequal; even though participants eschewed this idea, its influence nevertheless inflected their experiences. Some participants described their gratitude that their experience of serodiscordancy was so different to those experienced in the past, gratitude not only for the biomedical advances that transformed the risk landscape, but also to activists whose actions they saw as helping to realise those developments and the social progress of the last 30 years. Other forms of emotional labour included a participant experiencing intense emotions of sadness about his partner's diagnosis in response to depictions of HIV in popular culture, but not expressing them in order not to cause his partner upset. This emotional regulation was also discussed by other HIV negative participants at the point that they learned of their partner's diagnosis. While their first emotion was often one of sadness or

disappointment, they recognised the link between this feeling and stigmatised conceptions of an HIV diagnosis as being worth pity. While no participants expressed the view that HIV was blameworthy or made people living with the virus 'less than', other negative emotional responses to their or their partner's diagnosis belied the view that becoming HIV positive was something which deserved judgement or needed forgiveness. As well as these negative emotional reactions to HIV, broader discourses which construct people living with HIV as more vulnerable or deserving of pity also provided a reference point for participants who discussed how 'normal' their relationships were because of the robust way in which they treated each other, without concern for the potential fragility of their partner. I raise these experiences and this analysis not to suggest that participants were acting with false consciousness or were harbouring unconscious bias against HIV positive people, but to highlight how historical and wider social experiences of HIV colour and shape the emotional landscape in which participants were 'doing serodiscordancy'. These experiences highlight the emotional complexity and ambivalence inherent in receiving or learning of an HIV diagnosis in the era of biomedical prevention. An HIV diagnosis is often experienced as a loss – of health, of potential or of esteem (Walker, 2019). Yet community and biomedical discourses of normalisation suggest that these losses will not – perhaps even should not – be felt. This emotional complexity highlights how even normalisation can be associated with emotion work and also suggests that rather than an easy dissolution of stigma as a 'spoiled identity' (Goffman, 1963), it needs to be understood as a dynamic social process (Link and Phelan, 2001).

The work of serodiscordant sex

Applying the lens of 'work' to sex helps to elucidate how participants reconciled their lived experience of the relationship with popular discourses which emphasise sex as foundational to a good relationship and others which

emphasise particular kind of sex, with an emphasis on frequency and quality as hallmarks of a 'successful' relationship (Gabb, 2019). Participants discussed the importance of having 'enough' sex with their partner and their concerns that differences in appetite for sex might threaten the stability of their relationship. In several relationships, this interplayed with health and issues of ageing, with different partners adopting different 'strategies' to ensure that their partner was satisfied with sex that they were no longer interested in or found painful. This was also the case in relationships which became serodiscordant and, as a result, interrupted the partners' sexual relationship. For these couples, a 'good enough' sex life was negotiated within the context of their relationship, recognising what their partner liked, desired or needed. Participants navigated tightly woven influences of health and ageing, alongside changes in each other's appetites for sex over the course of the relationship as well as the influence of serodiscordancy on their sex lives. Although not all were wholly satisfied with their sexual relationship with their partner, they engaged with the need for patience and understanding. As I will explore further in the next section, echoes of Giddens's (1993) pure relationship resound in this focus not only on knowing and understanding what their partner desired, but also in the contention that what 'works' for each couple is ultimately the best solution. In this way, although a difference in status was the prompt for some of this exploration of different relationship forms or different sexual practices, serodiscordancy was not at the heart of their deliberations. For serodiscordant couples, this data suggests that ideas of what constitutes 'good sex' is supplemented with the idea central to TasP and U=U that condoms are no longer a necessary part of serodiscordant sexuality. As a result, some participants worked to make this part of their sexual relationship, managing their emotions and concerns about HIV which sometimes re-emerged during condomless sex. This affective management was also present for HIV negative participants who recognised the potentially stigmatising nature of their emotional reaction to first learning of their partner's HIV status, closely allied with the practices of silence discussed in the previous

section. Here I am not suggesting that 'doing serodiscordancy' is always associated with the suppression of negative emotions or concerns but wish to highlight that within this assemblage of practices and work, there are ways in which emotions are processed and expressed in different ways.

Further work of serodiscordant sex focused on participants reconciling their sexual practices with dominant discourses of 'safer sex' which emphasised the use of condoms and of individual responsibility. The relational nature of TasP served to overturn these imperatives and led to participants sometimes questioning whether their practices were responsible or safe. Participants sought to redefine the boundaries between responsible/irresponsible through both discursive practices and, for those in open relationships, enacting boundaries around who they would consider responsible partners to bring into their sexual relationship circle. In these discourses, participants shifted boundaries of (ir)responsibility to include condomless sex in the context of biomedical prevention and surveillance, as well as a deep knowing of their sexual partners. Robinson (2018) and Adam (2005) have highlighted how discourses of 'healthy' gay sexuality which emphasised unknown risks break down when partners become known or are no longer casual. The inclusion of deep knowing of partners, and their practices, into distinctions of responsibility brings to light how not engaging with (or even resisting) biomedical prevention and surveillance imperatives is now a locus of irresponsibility. Rather than the presence of virus or the practice of condomless sex, a lack of awareness of risk and of self-knowledge is the essence of the renegotiated boundary. Similarly at the boundaries of the serodiscordant relationship itself, both temporal and social, participants engaged in boundary work to define those who were aware of or open to the biomedical realities of TasP and those who continued to draw on stigmatising discourses of HIV. Through the deployment of discursive practices of 'advocacy' or 'education' or alternatively of silence, participants defined a boundary of acceptance/ignorance. This boundary work helped participants

define where and when to deploy the anti-stigma rhetoric of U=U and when to disengage and manage stigma through modes of secrecy and silence.

Despite the promise of U=U and TasP to relieve or simplify the emotional burden of HIV in serodiscordant relationships, this analysis of the work of 'doing serodiscordancy' points to the ways in which participants engaged in nuanced emotion work and affective regulation both in the everyday, in the sexual practices and in their interactions with others outside the relationship. In part, this work was to bridge the gaps between the promise of U=U and the old emotional landscapes and unchanged social 'myths' of HIV in order to achieve a state of HIV being 'irrelevant' in the everyday.

The theoretical implications of 'doing serodiscordancy'

One of the aims of this research was to bring together two bodies of theory in order to explore experience of serodiscordancy in a novel way. This section considers 'doing serodiscordancy' from the perspective of its theoretical framework and what this implies for the theories of biomedicalisation and intimacy that it has employed. It then explores issues of identity, of uncertainty and of the bridging of binaries that have been raised in Chapters 5, 6 and 7.

Biomedicalisation (Clarke *et al.*, 2003) is concerned with the processes through which biomedicine leads to social change and how those changes are themselves influenced by the social. 'Doing serodiscordancy,' provides an account of how these processes of transformation operate in the intimate sphere, emphasising the importance of the personal and the relational in how these changes are lived. These transformations include those around the meaning ascribed to an 'undetectable' identity and what that means for both positive and negative partners and how these are inflected through previous understandings of HIV. Engaging with theories of everyday intimacy highlight the way in which these transformations are often lived through 'ordinary

moments' and are embedded in practices, rather than in dramatic transformations. In 'doing serodiscordancy,' these include discussions between partners about risk and condom use, which through the lens of the everyday can be understood as an ongoing process, rather than a single 'fateful' decision point. The relationality of 'doing serodiscordancy' also highlights the entanglement of individual decisions in these relationship practices. Highlighting the dynamic nature of serodiscordancy as an ongoing practice rather than a static state also provides a counterpoint to biomedical accounts that presume homogeneity and stability. Further, by bringing in the messiness of everyday intimacy, this account also brings to the fore the inherent uncertainty and provisionality of transformations based on biomedicine in the everyday, as I will discuss further in *Absence and uncertainty*, below.

The insights into 'doing serodiscordancy' provided by engaging with intimacy theories corroborates their usefulness as analytic tools for examining what had often been assumed to be a primarily biomedical phenomenon. Mobilising the 'pure relationship' (Giddens, 1993) provided insights into how participants framed their experiences not only in terms of their own needs and satisfaction, but in terms of their partner's as well. Through this lens, the importance of maintaining each partner's health and the negative partner's status can be understood as protecting the stability of the relationship, and with it the sense of safety and security that it provides. It also makes sense of the way in which participants drew on their relationship and each other to define what 'worked for them' in the absence of external referents. That these rest on participant's understanding of their partner emphasises the importance of 'deep knowing' in serodiscordant intimacy. Applying this concept to serodiscordancy can also extend the reach of 'deep knowing' into the biomedical: partners in this study not only sought understanding of each other's motivations and desires but had access to biomedical insights of HIV status, viral load and treatment history. A focus on practices of caring highlighted how the biomedical can be incorporated

into relationships as opportunities for partners to express their closeness and specialness to each other. However, as with the criticism levelled at the 'pure relationship' explored in Chapter 3 (Jamieson, 1998, 1999), the analysis presented here points to the way in which ideals of equality and reciprocity were undermined in practice by influences outside the relationship. Societal emphasis on an HIV negative status as normative and more highly valued introduced imbalances which participants engaged in emotion work around to address. Intimate citizenship (Plummer, 2003) has helped highlight the way in which 'doing serodiscordancy' is structured through the social and the biomedical and how engagement with these discourses are productive of new forms of intimate practice. In contrast to the expectations of TasP and U=U that foreground the biomedical, these data in conjunction with 'telling sexual stories' (Plummer, 1995) highlight the importance of the intimate, and the engagement of those living those intimacies, in affecting social transformation.

Theoretical entanglements

In this thesis I have examined how the intimate and the biomedical are entangled in the lived experience of serodiscordant relationships. I have theorised that participants deployed an assemblage of everyday relationship practices and emotion work that I have termed 'doing serodiscordancy' to reconcile their lived experience of serodiscordancy with biomedical and societal discourses of how HIV and relationships should be 'done'. In doing so, it has called attention to how societal discourses of HIV, particularly the differential value placed on positive and negative serostatuses, play out within the intimate setting. By bringing together theoretical lenses of intimacy and biomedicalisation with a focus on how participants' relationships were lived as vital phenomena, it underlines the intricacy of the interaction between these factors – each mutually influencing and under the influence of the other. In their articulation of biomedicalisation theory, Clarke and colleagues (2003) highlight how the

changes wrought by biomedical technologies are evolutions rather than radical revolutions – what is articulated socially is realised through what has come before. This analysis highlights the unevenness of the spread of transformations of the meaning of HIV and of an ‘HIV positive, undetectable’ identity and suggests that the elements that are slowest and most resistant to change are rooted in individual biography and emotionality. Without wishing to undervalue the extent that TasP and U=U have transformed the experience of serodiscordancy, a close examination of the practices of ‘doing serodiscordancy’ reveals the extent to which old realities and responses shape the ‘new world.’ Plummer’s (2003) writing on intimate citizenship also highlights how ‘doing’ relationships can be productive of new forms of intimacy and viewing ‘doing serodiscordancy’ in this way suggests that by drawing on these discourses and practices, participants are articulating their own forms of biomedically mediated serodiscordant intimacy in the era of TasP. Through the discourse of U=U, the biomedical promises to transform serodiscordant sex in a similar way to Giddens’s (1993) ‘plastic sexuality’ – rather than heterosexual sex uncoupled from ‘risk’ of pregnancy in U=U serodiscordant sex becomes uncoupled from HIV transmission. But I have shown how enduring notions of responsibility and ‘spectres’ of risk trouble the serodiscordant intimacy imagined by U=U. The complexity and messiness of these theoretical entanglements points to the importance of engaging with intimacy **and** biomedicalisation in order to provide a rich account of phenomena such as serodiscordancy.

Absence and uncertainty

As I have highlighted throughout this thesis, uncertainty and provisionality were present throughout participants’ accounts. The relative invisibility of serodiscordancy, resulting in few templates of how to ‘do’ a serodiscordant relationship is in part a cause of the emotional labour. Making it ‘normal’ is challenging, not only because of the biomedical and specific challenges, but

also because of the lack of models on which to base relationship. In a similar way, same-sex relationships lack widely available cultural templates to draw from, with research suggesting that individuals work to define their own approach in a critical way which is more nuanced than simply asserting sameness or difference (Heaphy, Weeks and Donovan, 2014; Heaphy, 2018). In a study of same-sex relationships, Heaphy (2013) points to a picture in which acceptance of sexual minorities is becoming more widespread. Participants in the study reported more or less 'full' acceptance of their relationship among family and personal networks. Yet he points out that, despite the greater social visibility of sexual minority relationships, 'beneath this headline story there are also stories of estrangement, hostility and marginalisation.' Similarly with the experiences in this research, although all participants headlined that HIV was no longer important, they also reported experiences of rejection, of stigma and discrimination, and of fear. Uncertainty was also part of participants experience of 'doing serodiscordancy' because of its general cultural invisibility. As with Giddens's example of a lesbian relationship, which he presented as more 'pure' because of the lack of societal expectations around how it should be conducted, participants in serodiscordant relationships had few if any reference points for what serodiscordancy meant for them. Giddens highlighted a paradox of the pure relationship in his example. A lack of precedent gave license to the women in the relationship to explore their own and their partner's need, but without an external reference point, satisfaction became difficult to gauge. In this way, participants' experiences of serodiscordancy find some parallels with Giddens's thesis, in that many experienced uncertainty as to whether they were doing things in the 'right' way. I previously highlighted the simplified nature of Giddens's analysis, which neglected the influence of gendered and heteronormative discourses on same-sex relationships, and participants' experiences of serodiscordancy. This also highlights the complex interplay of factors which provided multiple ways in which their relationships could or should be done. I argue, therefore, that the uncertainty at the heart of their experience

of serodiscordancy relates to the clash between competing norms of heteronormativity and *seronormativity* overlaid with the biomedically informed discourse of U=U.

Part of the function of the practices and emotion work that participants engaged in 'doing serodiscordancy' was to help realise an everyday in which HIV was unimportant or even, absent. Nevertheless, what is absent can sometimes reappear and absences can themselves take on a paradoxical presence, looming large in consciousness as ghost or apparition (Scott, 2018). The 'spectres' of HIV that occasionally returned for participants therefore supports the notion the virus has become absent in everyday serodiscordancy. These occurred to both HIV positive and HIV negative participants. These spectres of HIV were associated with a return of the threat of transmission and were often associated with bodily fluids that had been potent symbols of infection, like cum and blood. Derrida (1994) calls this return of the suppressed, forgotten or never known, 'hauntology.' He suggests that this underlies all modern constructs that claim fact and certainty.

There is never complete or perfect knowledge; something is always lacking. There is always inherent uncertainty: 'from the knowledge to the decision, a leap is required, even if one must know as much and as well as possible before making a decision' (Derrida and Roudinesco, 2001: 92, cited in Egéa-Kuehne, 2003: 278).

Rather than a technoscientific understanding of risk or a sociologically informed phenomenological approach to risk (Lupton, 1999) these experiences and 'spectres' speak to post-structural approaches which frame risk in terms of fear of the unknown and unknowable (Gunder, 2008). In order to tackle this fear, society generates constructs of knowledge and certainty. In this conception, risk emerges from the gap between an idealised 'perfect knowledge' and the inherent uncertainty and provisionality of lived experience. By seeking to address uncertainty and fill this gap with further knowledge, the techno-

scientific project ultimately fails to address uncertainty in the moment of decision. By bringing HIV prevention science into the everyday lives of people living with HIV and their partners, and its emphasis on 'zero risk' U=U rhetoric fails to recognise the continued space for the doubts that participants reported to emerge and risks leaving those that it seeks to liberate and rather than addressing stigma and fear, has the potential to exacerbate it. I have argued that concerns about HIV transmission emerge from the gap between the idealised science of TasP and the uncertainty and provisionality of lived experience. In the 'messiness' of an ongoing intimate relationship, even with the reassurance of 'zero risk' provided by TasP, spectres of HIV will continue to emerge.

Bridging or bolstering binaries?

TasP has been highlighted as having the potential to 'bridge the serodivide' (Persson, Ellard and Newman, 2016) and make serostatus an insignificant factor in serodiscordant relationships. The data in this thesis speaks to some of the ways in which TasP has mitigated the influence of HIV on intimacy – literally through making the use of condoms unnecessary, but also for some couples by supporting the practices and emotion work through which they make it absent in the everyday. Yet those practices and the associated emotion work are still patterned by serostatus, embedded in a social milieu in which a negative serostatus is more highly valued than a positive one. So in this way, 'doing serodiscordancy' does not and cannot close the gap between the lived experience of HIV positive and HIV negative. Although 'undetectable' shifts boundaries of (ir)responsibility, those boundaries have yet to shift wider social values attached to a positive HIV status. In bridging the divide between the societal value of different statuses, participants drew on their relationship intimacy in a similar way to those living before TasP (Davis and Flowers, 2011) emphasising the importance of their relationship to each other and prioritising

love and commitment over considerations of HIV.

Serodiscordancy is an inherently relational phenomenon (Newman, Persson and Ellard, 2018) – but this troubles individualised notions of risk and responsibility. The role reversals of serodiscordancy in the era of TasP – *He's protecting me* – invert culturally dominant images of HIV positivity as requiring support and upset relational expectations of directions of care. However, where this arose within relationships in this research, it was often resisted through individualised approaches to risk management, such as the use of PrEP. In addition to the tension that serodiscordancy introduces between individual and dyadic risk prevention, by having at its core the notion of *difference* in status, it occasionally demands that attention moves away from the seronormative focus on HIV positive status as exceptional. This was most frequently seen in discussions of serodiscordancy with others outside the relationship when the relationality of disclosure of serodiscordancy by definition brought into contention participants' partner's status. This troubled individualised approaches to disclosure and also sometimes inverted expectations of disclosure of a positive status, necessitating participants to 'come out' as HIV negative. The frequent elision of serodiscordancy as a relational status of difference to 'one partner being positive' further highlights the pervasive nature of seronormativity.

Participants in this research also recognised that 'doing serodiscordancy' is predicated on certain social and political conditions, which they conceived of in terms of a bubble or a cocoon. For participants in the UK, where homosexuality is no longer illegal, the rights of same-sex individuals to marry are assured, and there is universal access to treatment, the experience of serodiscordancy has focused on the particular way in which stigma around HIV is managed. Even where homophobia is less of a concern, different medical systems and access to treatment can lead to the promise of TasP not being biomedically realised. The negative experience of HIV positive participants whose partners had seroconverted in earlier studies (Persson, 2010) suggest that although the

version of 'doing serodiscordancy' articulated by participants in this study frames the possibility of seroconversion as manageable, the reality can have a significant impact on the relationship and particularly on HIV positive individuals. These studies in other contexts highlight the material and social bounds of 'doing serodiscordancy' and highlight the contingency of the intimate and the affective on the biomedical, emphasising the importance of social and political influences in the biomedicalisation of HIV in TasP.

These data also trouble the discourse associated with U=U, in particular its construction of certainty (through 'zero risk') and the way in which it flattens and homogenises experiences of living with the virus. The presentation of understanding U=U as 'a lightbulb moment' dramatizes the revolutionary potential of TasP for intimate relationships. But although some participants did experience similar moments of conversion, the partial and ongoing engagement with TasP in the everyday, particularly in relation to sexual practices, troubles the binary presentation of U=U as fully accepted or not. These data also bring to light a tension between U=U discourse painting acceptance of TasP as a static *fait-accomplis* and the experiences of participants in which serodiscordant relationships are a vital project within which dynamic process of gradual (or dramatic) acceptance, reversals and losses of confidence take place. As I argued in relation to ways of understanding disclosure of serodiscordancy in Chapter 7, understanding these processes through the lens of 'ordinary moments' rather than single 'fateful moments' provides a way of understanding change in a way that is embedded in everyday lived experience (Gabb and Fink, 2015a).

Extending this research

This section examines how the findings of this study could be extended by future research, both those relating specifically to a deeper investigation of the phenomenon of serodiscordancy and also beyond it, seeking to examine the role of intimacy in other biomedical contexts.

Further research with a specific focus on reaching and recruiting those in serodiscordant relationships from different social classes and ethnicities is warranted, particularly given recent studies which highlight the intersection of racism, HIV stigma and homophobia experienced by individuals of minority ethnic groups in the UK (Arnold, Rebchook and Kegeles, 2014). In the research sample for my study, no participants identified as bisexual or raised experiences of heterosexual serodiscordancy. Other studies have highlighted the role of race and reproduction in heterosexual serodiscordant couples (Bourne, Owuor and Dodds, 2017), an understanding of which would further expand and enrich the understanding of 'doing serodiscordancy' in the UK. Engagement with TasP has been shown to be influenced by individual medical biography, HIV generation, sexual cultures and belief in biomarkers (Young *et al.*, 2019). Greater diversity within the sample would therefore be anticipated to capture a greater range of engagement with TasP, which for the participants in this sample was fundamental to the way of 'doing serodiscordancy'. Other levels of awareness of and engagement with the concept of TasP or with science and medicine in general, could result in different articulations of 'doing serodiscordancy'. Although other relationship forms were not excluded from the study, all participants in this sample were in couple relationships. The intimate relationship practices I examined are therefore exclusively couple related, although participants in open relationships did touch on the sexual practices of intimacy relating to other partners. Supplementing this with an understanding of how 'doing serodiscordancy' operates in everyday relationships in which more than one partner shared a serostatus could reveal more about how the imbalances of serodiscordancy are negotiated. Finally, during the course of this study, several serodiscordant couples shared their experiences and discussed TasP in newspaper features (e.g., Nagesh, 2017), in addition to primary data gathered through interviews and diaries, future research could include these secondary sources to further study the way in which TasP and serodiscordancy are presented to the public.

In my analysis of the data, there did not appear to be variation in experience aligned with point of diagnosis in history of epidemic, however there was over-representation of more recent diagnoses within the sample. Given that other studies of the experience of living with HIV have suggested significant differences and variability over 'generations' relating to treatment in the UK (Rai *et al.*, 2018) further investigation of potential differences in experience and in ways of 'doing serodiscordancy' would be worthwhile. Although the role of ageing was highlighted in some places in this study, this was also co-occurring with changes in relationships over time. Further examination of the dynamics of both HIV and of relationships over time could help to draw distinctions between 'doing serodiscordancy' in different stages of relationship or any patterns of temporality. One of my arguments is to consider 'doing serodiscordancy' as a 'vital project' (Heaphy, 2018) which has dynamism and changes over time. Foregrounding the continuous re-emergence of doubt as 'spectres' of HIV, it also resists the notion of easy progress towards an untroubled 'acceptance' of TasP. A longitudinal investigation of the experiences of serodiscordancy over time could provide greater insight into these processes and the range of serodiscordant relationship trajectories. This focus on trajectories of serodiscordancy could be further expanded by including past experiences of serodiscordant relationships that broke up.

As highlighted in Chapter 7, serodiscordancy is often collapsed to one of the partners in the relationship being HIV positive, rather than being understood as a relational difference itself. While this highlights the normative value placed on a negative HIV status, it has made serodiscordancy a 'slippery' phenomenon to study, with experiences of serodiscordancy often conceived of and presented as the experience of being HIV positive in a relationship. Further research that focuses more closely on data generated through engagement with dyads, both serodiscordant, serodiscordant and with other relationship formations might through highlighting commonalities and contrasts generate further insight into

the relational, emergent nature of serodiscordancy. Consistent with other research, this study has considered serodiscordancy as a phenomenon of stable relationships. Further insight into the intersection of the biomedical and the intimate could be provided by an examination of how the biomedicalisation of HIV prevention, for example the identities of 'undetectable' and 'negative on PrEP', is being drawn on in other intimate contexts, such as casual sexual encounters, how these transformations are being negotiated in the context of on-line intimacies.

In addition to the studies that could provide deeper examination of serodiscordancy outlined above, the findings of this research suggest that further studies of how the biomedical and the intimate combine to produce new ways of 'doing' intimate relationships may prove illuminating. In particular, the way in which ageing, biomedicalisation and how relationships themselves age are intertwined and play a role in the everyday practice of relationships has been a finding which could be further explored not only in serodiscordant relationships, but in the context of other long-term relationships in the presence or absence of chronic health conditions in partners. One of the key transformations of biomedicalisation is focused on risk (Clarke *et al.*, 2003; Collin, 2016; Langdridge, 2016) and the way in which the processes of biomedicalisation create and transform identities of those 'at risk.' In this study, I have argued that discontinuities between technoscientific and post-modern conceptualisations of risk have resulted in the creation of 'spectres' of HIV risk that continue to play a role in participants' experiences, despite a biomedical transformation which suggests transmission risk is now removed. With other once acute conditions such as cancer increasingly transformed into chronic, biomedically mediated states managed with long-term medication, the influence of these transformations of risk on the experience of the everyday and on relationship intimacy could prove a fertile ground for further exploration and theorisation. This research has also focused on the way in which participants

incorporated biomedically transformed ideas of risk in their sexual practices, both within their relationship and, for those in open relationships, with other partners. Further research could expand upon and examine how the boundary work of (ir)responsibility that participants deployed in bringing outside partners in, or excluding them from their sexual practice, and consider how these processes might operate in other stigmatised conditions which have been transformed through biomedicine, for example in hepatitis C (HCV) infection in gay and bisexual men. Examining how the nexus of biomedical risk transformation and 'responsible' sexual practice operates in the setting of another chronic viral condition which can be transmitted sexually and through sharing injecting equipment would further extend the findings of this study. In addition, the availability of anti-viral drugs which can cure HCV infection provide a modified biomedical context in which biomedical identities (for example, HCV-cured, HCV-reinfected) interact with intimacy.

Implications for practice

Finally, I turn to what the findings of this research imply for those who engage with gay and bisexual men in serodiscordant relationships. The way in which participants engaged with TasP in their sexual practices and the trouble they had reconciling these practices with safer sex discourses adds to an established and ongoing critique of condom-centric and individualised safer sex messaging (Adam, 2005, 2016; Davis, 2008; Keogh, 2008a; Robinson, 2018). Biomedical approaches to prevention are inverting approaches to safer sex and are productive of new strategies and adaptations. As with previous 'innovations' which later led policy (Flowers, 2001), these data provide an opportunity for updated approaches to communicating about HIV prevention and risk which more closely reflect the way in which men in serodiscordant relationships are engaging in sex. In addition to these considerations, participants were engaged in redefining boundaries of (ir)responsibility in a way which does not align

directly with particular practices but with their experiences of intimacy and deep knowing. Revisiting and reworking HIV prevention campaigns in the light of these experiences could help increase their efficacy through greater credibility and help to avoid the transfer of stigma from HIV positive undetectable people to those who are unaware or do not engage with HIV medicine.

Although these data show how some people in serodiscordant relationships practise, it does not necessarily follow that they provide a blueprint for others to follow. This is a description of how things are and therefore departs in some places from how things 'ought to be' from the point of view of U=U. By providing an account of how relationships are done in practice, including the elements of uncertainty and pieces which do not follow the U=U rhetoric, this research can help to support a nuanced understanding of how serodiscordant relationships operate. This in turn could help to provide realistic expectations for interventions to support people adjusting to or needing support in serodiscordant relationships. It also highlights areas in which participants were uncertain about biomedical aspects of HIV prevention, in particular relating to the stability of an undetectable HIV status, what factors might influence an individual's viral load and the applicability of TasP to transmission via blood, to name but a few. Participants were sometimes concerned about the stability of their undetectable status and were anxious about moves towards less frequent viral load monitoring. Involving people living with HIV in serodiscordant relationships in decisions about the frequency of blood monitoring may help reduce uncertainty and anxiety. However, as I have outlined above, this thesis also highlights the importance of allowing space for and accepting the potential for uncertainty around serodiscordancy. A technoscientific understanding of risk based on clinical trials is incommensurate with the partial, inherently unknowable way in which risk operates in the day-to-day lived experience. I would therefore argue that seeking to continually provide certainty and reassurance could be counterproductive as people in serodiscordant relationships continue to

encounter moments of uncertainty or doubt which are not acknowledged in the discourse of U=U.

I have shown how this uncertainty led participants to engage in emotion work around the gaps they experienced and could result in distress. In this way, although TasP and other biomedical approaches to HIV prevention are largely anticipated to reduce anxiety relating to transmission (Young, Flowers and McDaid, 2015; Whitfield *et al.*, 2019), there is the potential for unaddressed (and indeed *unaddressable*) uncertainty to provoke continued anxiety. Part of the uncertainty participants experienced relating to TasP in the everyday centred on the unknowability of an individual's viral load at a particular moment. The 'leap' (Derrida, 1994) that they had to make around the stability of an undetectable viral load sometimes led to a loss of confidence. Although this has been anticipated by the U=U movement, who have focused communication on the general stability of viral loads and the irrelevance of temporary 'blips' for transmission (Prevention Access Campaign, 2017), the shift of the focus of uncertainty and the post-structural approach to risk I outlined earlier in this chapter suggests that recognising the potential for uncertainty, rather than continuing to try to continually reassure might be more congruent with the experiences of participants. Indeed, in emphasising certainty and the stability of an undetectable viral load, U=U communications could be undermining their effectiveness. A recent study suggested that although the majority of positive participants in a serodiscordant relationship reported they were undetectable and were not using condoms, viral load testing during the study indicated that a significant proportion had a detectable viral load (Stephenson *et al.*, 2020). The need for continued engagement with care in order to maintain undetectability, along with its importance in maintaining serodiscordancy underlines Philpot's suggestion that couples relying on an undetectable viral load for HIV prevention make an explicit agreement about the steps that they will take, including regular viral load checks (Philpot *et al.*, 2018). These

recommendations could be expanded to recognise and make space for complexity and uncertainty in the everyday practice of a serodiscordant relationship.

Recognising and embracing the sources of uncertainty relating to TasP in participants' experiences as an inherent part of the experience of serodiscordancy invites a different engagement with serodiscordancy. The uncertainty that participants expressed around whether their practices *really* were safe becomes an epistemological phenomenon rather than a need to be addressed through an educational programme. Participants' concerns that they might not correctly translate what they knew about TasP into their everyday practices can be recognised as a consequence of TasP being at heart a scientific concept that does not directly translate into lived experience. And the 'spectres' of HIV transmission that return during sex or when confronted with blood are part of lived experience that cannot be explained away by further reassurances around the stability of an undetectable viral load. Rather than seeking to expunge doubt and uncertainty from the lived experience of serodiscordancy, those engaging with men in same-sex serodiscordant relationships could instead recognise the inherent nature of doubt and the role that an intersection of a plethora of biographical, geographical and communitarian factors play in shaping individuals' engagement with HIV science. Rather than assuming that everyone will eventually reach a full acceptance of this message, instead make space for a pluralistic range of engagements with what TasP means in a particular relationship. That is not to say that men in same-sex serodiscordant relationships would not find benefit in bespoke packages of education and support which have been developed in consultation with couples (Bazzi *et al.*, 2016; Mitchell *et al.*, 2018). In addition to the benefits reported to those participating in these programmes, sharing experiences and the 'stories' (Plummer, 1995) of serodiscordancy could help those in serodiscordant relationships to engage with and express ideas of how serodiscordant relationships can be practiced, which

then have the potential when articulated publicly, to transform social norms (Plummer, 2003; Persson, Ellard and Newman, 2016).

Summary

In this thesis, I have placed TasP in the context of an ongoing biomedicalisation of HIV that has privileged scientific accounts of 'progress' and examined how community and intimate responses have been overlooked. I have traced the development of TasP, and latterly U=U, as an epidemiological concept that has become not only a driver of treatment but also been positioned as a tool with the potential to effect social transformation. I have drawn on critiques of HIV science to argue that because the scientific method that created TasP actively excludes the social, it paradoxically neglects the very contexts in which it will operate. I have argued that this research therefore plays an important role in providing an account of the lived experience of serodiscordancy and contributes to a growing literature which seeks to examine it as a phenomenon in its own right. Drawing on a phenomenologically informed thematic analysis of interview data, I have explored how participants experienced HIV as somehow absent in the everyday and the practices and emotion work that they engaged in to sustain these experiences. I have considered the place of sex in a serodiscordant relationship and how understandings of TasP have overemphasised the centrality of sex in serodiscordant intimacy. Nevertheless, participants drew on their understanding of TasP to inform their sexual practices and engaged with existing understandings of sexual safety to articulate new boundaries of (ir)responsibility. I have also considered how participants engaged with stigma in relation to serodiscordancy, how norms relating to serostatus focused this on the HIV positive partner, and how participants managed their relationships with others through practices of education and silence. Finally, I have considered how despite the experience of HIV as absent, it continued to have a presence throughout these experiences of serodiscordancy. I have argued that a

discontinuity between the scientific nature of knowledge supporting TasP and everyday lived experience means that uncertainty is an inherent part of 'doing serodiscordancy', which has implications for the way in which serodiscordancy is portrayed and campaigns such as U=U are communicated. The messiness of intimacy, coupled with the complexity of processes of biomedicalisation, means that programmes which seek to eliminate uncertainty about or achieve perfect acceptance of TasP to eliminate stigma will be doomed to failure and can paradoxically provoke greater ambivalence and distress. Instead, working from an understanding of the multiple everyday contexts in which serodiscordancy is lived can articulate new intimacies that have the potential to transform society.

Afterword

At the end of this thesis, I would like to briefly return to the question that seduced me during early stages of analysis, ‘does HIV matter in relationships anymore?’ As the previous 250-odd pages attest, it is not a question that can be answered in a straightforward or unequivocal way! Yet through conducting this research and talking to participants, there was a sense that TasP had made a significant positive difference to their lives and relationships that it would be remiss of me to neglect. Even if HIV does still matter, it certainly matters less.

*What does [TasP] mean to me? Er. Tally ho, chocks away, come here!
Let's have sex [laughs] [...] It is a condition that we can live with just
by – I say just – by taking medication. It's not the big ogre that is
circling the room. It's almost to have a weight lifted... perversely, it
is having the weight lifted off, now, being positive and undetectable.
It's not the thing that I thought it was and it certainly is neither the
tombstone nor the iceberg*

Richard (46, HIV positive)

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Appendices

Appendix A: Recruitment materials

Postcard



**What is it like to be in a
relationship with someone
with a different HIV status?**

youmestudy.wordpress.com

HIV has changed.

**We know that treatment makes it possible to live well
with the virus without passing it on.**

This has transformed how HIV is treated and prevented.

**But what does it mean for men living with the virus and
their partners?**

To understand more about everyday life and love with HIV, we
would like to talk to men who are in a relationship with a man
with a different HIV status.

To find out more, visit youmestudy.wordpress.com

Email tom.witney@open.ac.uk or peter.keogh@open.ac.uk

Call 01908 653805

All enquires treated with strictest confidence

This research is being conducted by Tom Witney for his PhD at the Open University, supervised by Dr Peter Keogh.
It has been approved by the Open University Human Research Ethics Committee HREC/2565/Witney



YOU+ME

What is it like to be in a
relationship with someone with a
different HIV status?

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This research is being conducted by Tom Witney for a
PhD at the Open University, supervised by Dr Peter
Keogh. It has been approved by the Open University
Human Research Ethics Committee HREC/2565/Witney



The Open
University

Appendix B: Ethical approval

Human Research Ethics Committee (HREC)

From Dr Louise Westmarland

The Open University Human Research Ethics Committee

Email louise.westmarland@open.ac.uk

Extension (6) 52462

To Tom Witney

Project title YouMe: Examining the experiences of male same-sex serodiscordant couples in the UK

HREC ref HREC/2565/Witney

AMS ref



The Open
University

Memorandum

Date application submitted: 03/05/2017

Date of HREC response: 20/06/2017

This memorandum is to confirm that the research protocol for the above-named research project, as submitted for ethics review, has been given a favourable opinion by The Open University Human Research Ethics Committee.

Please note the following:

1. You are responsible for notifying the HREC immediately of any information received by you, or of which you become aware which would cast doubt on, or alter, any information contained in the original application, or a later amendment which would raise questions about the safety and/or continued conduct of the research.
2. It is essential that any proposed amendments to the research are sent to the HREC for review, so they can be recorded and a favourable opinion given prior to any changes being implemented (except only in cases of emergency when the welfare of the participant or researcher is or may be effected).

3. Please include your HREC reference number in any documents or correspondence, also any publicity seeking participants or advertising your research, so it is clear that it has been reviewed by HREC and adheres to OU ethics review processes.
4. You are authorised to present this memorandum to outside bodies such as NHS Research Ethics Committees in support of any application for future research clearance. Also, where there is an external ethics review, a copy of the application and outcome should be sent to the HREC.
5. OU research ethics review procedures are fully compliant with the majority of grant awarding bodies and where they exist, their frameworks for research ethics.
6. At the conclusion of your project, by the date you have stated in your application, you are required to provide the Committee with a final report to reflect how the project has progressed, and importantly whether any ethics issues arose and how they were dealt with. A copy of the final report template can be found on the research ethics website - http://www.open.ac.uk/research/ethics/human-research/human-research-ethics-full-reviewprocess-and-proforma#final_report.

Best regards

Dr Louise Westmarland

The Open University Human Research Ethics Committee

www.open.ac.uk/research/ethics/
January 2017

Appendix C: Participant information



What is the aim of this research?

The purpose of this study is to understand the experiences of gay and bisexual men in serodiscordant relationships (relationships where partners have different HIV statuses). The study will focus particularly on the day-to-day experiences of being in a serodiscordant relationship.

Who is conducting the research and who is it for?

Tom Witney is carrying out this research as part of his PhD at the School of Health, Wellbeing and Social Care at The Open University. Tom has received training in carrying out research interviews and has worked as a volunteer in HIV and sexual health for 8 years. He is a member of the Reproduction, Sexualities and Health research group, which designs, carries out, and analyses research in the fields of reproduction, sexuality and health. Further information about Tom and the group can be found on their webpages:

<http://www.open.ac.uk/people/tw3639>

<http://wels.open.ac.uk/research/reproduction-sexualities-and-health>.

If I take part in this research, what will be involved?

Participating in this research will involve three activities spread over a few weeks. These are: keeping a diary for a week, being interviewed on your own and then being interviewed with your partner(s) on a different day. We will be conducting interviews from June to December 2017. The interviews will take approximately one hour each and would be conducted at your home (or another location if you prefer), at a date and time that is convenient to you. To ensure your safety, Tom will identify himself with photographic identification.

Participating in the research is voluntary and you can withdraw from the study at any stage for any reason without penalty. If you decide to withdraw during an interview, or up to one month after the interview, the data from that interview will not be used in the study. If you decide to withdraw more than one month after an interview has taken place, ordinarily your data will have been processed and it may not be possible to remove your data from analysis. If your partner withdraws from the study after your interview together, your data from that interview may not be included in the study, but this will be discussed with you and your partner.

What will the taking part in the research be like?

As outlined above, taking part in the research will involve committing to keeping a diary for a week, being interviewed on your own and then being interviewed with your partner(s). This will mean you will be involved in the research for a few weeks, but each activity should not take up too much of your time.

You can keep the diary in a format that is convenient for you (for example, written in a notebook, typed on a computer or recorded on a smart phone). You will be given some guidelines on the kind of thing to focus on in your diary, but you are free to include other things if you would like.

Both the interviews will be informal and will involve having a conversation with the researcher for approximately an hour.

Although this research is not intended as counselling or to help improve relationships, people who have participated in similar studies have said that they found participating in the research interesting and that they learned about their relationship and themselves.

What will we be talking about?

The focus of the individual interviews will be your diary and your experiences and feelings about your relationship. When you are interviewed together, the interviewer

will ask you and your partner(s) about a number of different topics relating to relationships and how they apply to your relationship.

The interviews may involve you talking about difficult or unpleasant experiences. If, during either interview, there is anything that you do not wish to talk about, you can skip the question. If you or your partner(s) are upset by the interview, you do not have to continue and can stop at any time. If you or your partner(s) are particularly upset, Tom can provide you with information on sources of support, or refer you for counselling.

Is it confidential?

Your participation will be treated in **strict confidence** in accordance with the Data Protection Act. No personal information will be passed to anyone outside the research team. I will write a report of the findings from this study, but no individual will be identifiable in published results of the research. Data generated will be stored on secure servers at The Open University and will be destroyed after 10 years. Anonymised research data may be made available to other members of the research community through The Open University's Open Research Online for a period of 10 years.

During your individual interview, you may talk about experiences and feelings that you have not discussed with your partner(s) or that you would not wish them to know. I will take steps to make sure that **what you tell him is kept confidential and will not be shared with your partner(s)** during the research. Before being interviewed together, you will have the chance to let me know any topics that you would like to avoid discussing with your partner(s) and they will not form part of the final interview.

What happens now?

Over the next few weeks, Tom may contact you by telephone to ask if you would like to take part and, if so, ask you a few questions about yourself. We need to make sure that a cross-section of people with different experiences are included in the study and for this reason we cannot guarantee that we will see everyone who volunteers to take

part, although we would hope to include most. Your participation is entirely voluntary.

What if I have other questions?

If you have any other questions about the study, Tom would be very happy to answer them.

Please contact Tom Witney (tom.witney@open.ac.uk, 01908 653805)

Alternatively, please contact Tom's supervisor, Dr Peter Keogh
(peter.keogh@open.ac.uk, 01980 654946)



Methods information and instructions for participants

Thank you for agreeing to participate in this research. This document contains information about how to complete your diary and what the interviews will involve. If you have any questions, please let Tom know. You can contact Tom, or his supervisor using the details at the end of this document.

Diaries

Diaries aim to find out about your everyday routines, for example what you did and when. You should complete your diary over a one week period, at a time and in a place that suits you. You can use it to reflect upon any aspect of your relationship during the week, writing as little or as much as you like.

The diary can also become a kind of scrapbook. As such, you could include mementos (if any) of any time you spend together. These could take the form of TV guide clippings or receipts for the cinema, for example, or maybe the label from a bottle of wine or beer, a menu from a meal out or take away, or the packaging from a shared meal at home. You can include pictures that you have taken if you'd like to.

The diary format is flexible. You can use the notebook I give you, a Word document on a computer, or an Outlook calendar on your phone. Use whatever works for you. Photos can be attached to an electronic file and sent to me. I am happy to print these out for you. You can then simply describe where they fit in your diary and leave a space for them.

In your written diary, I would like you to include your experiences of some or all of the following areas:

- Any time that you spend together with your partner, including the kinds of activities you did and the times of day and duration of these activities

- Any time that you spend apart from your partner, including the kinds of activities you did and the times of day and duration of these activities
- Any things, both inside and outside the home (such as your job, TV programmes etc.), that have made you think about and/or have affected your relationship in some way
- Any conversations or contact with people (such as your family, friends, children etc.), who have made you think about and/or have affected your relationship in some way
- Anything that you or your partner have done (gestures, actions, words) for each other
- Anything that you have done for yourself
- One good moment in each day
- One challenging moment in each day

Once you have completed your diary please send or give it back to me in whatever format you have chosen. I will make a copy and this will be used as the basis of the first interview, when you will be asked to talk through your week with reference to the diary and the experiences and interactions.

Interview 1: Individual - you

Your individual interview is in two halves and will be completed with you on your own. In the first half of the interview, I will invite you to talk about experiences and different relationships across your life.

During the second half of this interview, we will talk through the events and experiences that you have described in your diary. You will can tell me about the detail of these events, what they mean to you and fill in any gaps that you have identified, that is to say anything that you forgot to include at the time or perhaps fleshing out an experience that you may only briefly described in your diary, for example.

Interview 2: Relationship

In the second interview, I will talk to you and your partner(s) together. This will

ordinarily be completed on a separate day to your individual interview. You will be shown a series of topics that relate to different aspects of long-term couple relationships. You will then be asked to respond to these topics and to reflect on how these connect with or diverge from your personal experiences.

If you have any other questions about the study, please contact Tom Witney (tom.witney@open.ac.uk, 01908 653805) or Dr Peter Keogh (peter.keogh.open.ac.uk, 01980 654946)

Appendix D: Consent form

YOU±ME

QUALITATIVE RESEARCH CONSENT FORM:

participant serial number:

Consent to be interviewed by Tom Witney:

Please initial boxes below

I confirm that I have read / had read to me the leaflet, about this research project and I understand the content.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time during the interview and for one month afterwards, without giving a reason.

☐

I understand that the interview will be recorded and written out word-for-word later. Any details that could identify me (e.g., my name, my partner's name, etc.,) will be changed to protect my identity..

☐

The recording will be securely stored in accordance with the Data Protection Act.

I understand that anything I say will be treated confidentially and only used for research purposes, in accordance with the Data Protection Act.

☐

I agree to take part in the YOU±ME research study

☐

I would like to see the final report of the results of this study

☐

Name of participant

Date

Signature

Name of researcher

Date

Signature

1 copy for participant; 1 copy for researcher

Appendix E: Individual interview discussion guide

PART 1: You and your relationships (20 mins)

First, I'm going to ask you about when you first started to get involved emotionally with others and first started having sex, and then I'm going to ask you a bit about how things have changed for you since then

Going right back to the beginning, tell me about when you first started having relationships/dating/getting intimate with someone?

- Your age/year?
- The context?
- Who was it?

And what about when you started having sex?

- Age/year?Context?
- Were your earliest partners men / women?
- When did you first have sex with a man?

When did you first become aware of HIV?

- What role did HIV play in your life at that time?

So now that you've told me about 'the early days', do you think you have changed much in the way that you think about:

- Relationships?
 - If yes, what is different?
 - If no, what has stayed the same?(What's good/bad/desirable/undesirable)
- Sex?

- If yes, what is different?
 - If no, what has stayed the same?
- (What's good/bad/desirable/undesirable)

- HIV?
 - If yes, what is different?
 - If no, what has stayed the same?

(how important it is, what it means, sexual safety)?

PART 2: Your current relationships (20 mins)

Now I'd like to talk to you about your current relationship

Tell me a bit about your current relationship, how does it work?

- Story of meeting
- When did serodiscordancy become known?
 - How was that?

How does this relationship compare to other relationships you've had in the past?

- (Money/family/friends/health/place to live/job/sex/health/HIV)

What are the factors that makes this relationship better/worse/different to those other relationships?

- (Money/family/friends/health/place to live/job/sex/health/HIV)
- *Probe: you mentioned [money], can you give me an example of a time [money] has helped/hindered?*

Where do you see this relationship going? How would you like to see it

develop?

- What factors are likely to help/hinder it developing in the way you want it to?
- OR What factors might threaten or change your relationship?

You've told me lots about the things that play a role in your relationship. Does HIV play any role? What role?

- Tell me about time(s) that HIV was important in this relationship. What happened? How was it?
- Did HIV play a different role in this relationship in the past? OR Did HIV play a different role in past relationships?
- Compared with when you first became aware of HIV, how is this different for you?

Tell me about a time you were particularly aware of having a different HIV status to your partner

- What happened? How was it?

Is having a different status to your partner something you think about or talk about with anyone else?

- If yes, tell me about a time you thought about it/discussed it with someone. How was it?
- If not, can you tell me about a time you thought about or wanted to discuss it with someone else, but didn't

What does your status mean to you now?

What does your partner's status mean to you now?

- How would you feel if [negative partner's] status was to change?
- How might that happen? What would that mean for your relationship?

PART 3: Let's talk about sex (20 mins)

In this part of the interview I will be asking questions that will help me to gain a better idea of what your sex life is like for you these days, and how you feel about it.

Tell me about your sex life in general...how is it going for you?

- In specific ways / circumstances?
- What aspects do you most / least enjoy?

Lots of people use the term safer sex. What does that term mean to you?

- Has your understanding of what is safer sex changed?
- What has influenced these changes to your understandings?

Can you take a moment to think about the last time you had sex with your partner (*or particular episode from diary*)

- Can you remember if there was anything that you thought about, considered, or weighed up beforehand?
- Was there any conversation between you before having sex? What about?
- Who did what, to whom?
 - Condoms? How discussed?
 - Drugs? What, who did?
 - Who came, where?
- How did you feel about the sex while it was happening?
- How did you feel about it afterwards?
- We talked earlier about your thoughts on safe sex. How did this occasion fit in with that thinking?

- Now can you think about different sexual encounter you may have had recently – either a different kind of experience, or in a different place, or because it was with a different partner
 - First tell me how it was different from the other time you just described
 - Can you remember if there was anything that you thought about, considered, or weighed up beforehand?
 - Was there any conversation between you before having sex? What about?
 - Who did what, to whom?
 - Condoms? How discussed?
 - Drugs? What, who did?
 - Who came, where?
- How did you feel about the sex while it was happening?
- How did you feel about if afterwards?
- We talked earlier about your thoughts on safe sex. How did this occasion fit in with that thinking?
- [If time] What one thing would improve your current sex life?
 - What would help you to achieve that?

Wrapping up

- Anything that you were expecting to talk about that we missed?
- Advice for others of same status in serodiscordant relationship?
- How has this process been for you?

Appendix F: Couple interview flashcards

SEX & DRUGS	NEWS & POLITICS
HIV	SOMETHING ELSE...
PHYSICAL AFFECTION	MONEY & WORK
FAMILY & FRIENDS	HOME & CHORES

MEDIA & TECHNOLOGY	HEALTH & MEDICINE
CHILDREN & PETS	GOING OUT
HIGH POINTS	LOW POINTS
ROUTINE	

<p>STAYING IN, GOING OUT</p>	<p>COOKING & EATING</p>

Relatively normal? Navigating emergent sensitivity in generating and analysing accounts of ‘normality’

Abstract

This article describes methodological and ethical issues associated with examining discourses of ‘normality’ in the context of the normalisation of HIV and relationships. It considers how sensitivity was anticipated and proactively managed in the recruitment of participants and during research interviews and discusses the implications of these approaches in this particular project. It reflects on the tensions present when generating data on topics externally deemed to be ‘sensitive’ but considered ‘normal’ by participants. In doing so, it has wider relevance for research on experiences that were once prohibited but are now considered normative in some settings, such as gay marriage. However, highlighting the importance of ‘the normal’ in notions of stigma, it concludes that potentially any research project which examines or questions ‘normality’ may give rise to sensitivity.

Key words

HIV, serodiscordant relationships, sensitivity, normalisation

Sensitive research is often defined by its engagement with topics that intrude into the private sphere, relate to issues of non-normative, taboo or stigmatised subjects (Lee, 1993; Dickson-Swift, James and Liamputtong, 2008). Despite the myriad of methodological challenges posed by research which provokes sensitivity, it has proven to be a rich seam for sociological investigation partly because the sensitivity itself signals phenomena of social significance (Lee, 1993; Dickson-Swift, James and Liamputtong, 2008). At the other end of the spectrum, the everyday and the ordinary have also been the focus of a significant sociological literature (Jacobsen, 2009). In contrast with a traditional sociological focus on the unusual or deviant (Matza 1969, Downes and Rock 1988, in Lee, 1993, p. 11), a sociological examination of the ‘normal’ has merit precisely because it is often overlooked (Jacobsen, 2009; Scott, 2018). Researching the ‘normal’ is associated with methodological challenges, because its taken-for-granted nature means that it is often hidden or unseen but it is rarely associated with the challenges of sensitive research. However, as the other papers in this collection attest, problems associated with sensitivity can also arise in otherwise uncontroversial research (Robb, *in preparation*, Tilley et al, *in preparation*). Recognising the importance of context for making research sensitive (or not), Lee suggests considering the conditions in which sensitivity arose in the research process rather than seeking to define sensitivity only in terms of its subject matter (Lee, 1993, p. 3). This approach shifts the focus from the subject of research towards its conduct.

In this research note, I will adopt Lee’s approach to consider how sensitivity arose in relation to questions of normality. This paper draws on interview data and reflexive journal entries from a qualitative investigation into the lived experience of thirty gay and bisexual men living in the UK who have a different HIV status to their partner (Author, forthcoming). Here, reflexivity refers to the dual processes of introspection undertaken to examine the relationship between the researcher’s lifeworld

and the data (Finlay, 2011) and the interrogation of the influence of epistemological commitments on the execution of research (Braun and Clarke, 2019). I will explore how competing discourses of HIV stigmatisation and normalisation produced sensitivity in the research encounter and reflect on how I managed these emergent issues in order to complete the project. Finally, I will consider the methodological implications for other researchers working in subject areas which bridge processes of normalization and stigmatization.

Relationships where the partners have different HIV statuses (known variously as serodiscordant, sero-different or ‘magnetic’ relationships) have been the focus of medical and sociological study since early in the HIV epidemic (Mendelsohn *et al.*, 2015). Serodiscordant relationships were considered sites of significant transmission risk, particularly with evidence of inconsistent condom use in sexual activity (Crawford *et al.*, 2003; Stolte *et al.*, 2004; Hoff *et al.*, 2005; Poppen *et al.*, 2005; Van de Ven *et al.*, 2005; Guzman *et al.*, 2006; Ostrow *et al.*, 2008; Prestage *et al.*, 2009; Horvath *et al.*, 2012). Moreover, such relationships have been subject to various stigmatizing impulses (Persson, 2008, 2011, 2013a, 2013b). However, recent medical research has demonstrated that effective antiretroviral therapy prevents sexual transmission (“treatment as prevention” or TasP), even in the absence of other methods of prevention (Cohen *et al.*, 2011; Rodger *et al.*, 2016; Bavinton *et al.*, 2018). While some point out the potential of this ‘medical breakthrough’ to subordinate the complex social aspects of the epidemic (Nguyen *et al.*, 2011) others have taken this as an opportunity to reframe serodiscordant intimacy, as safe and legitimate (Persson, Ellard and Newman, 2016; Bourne, Owuor and Dodds, 2017; Newman, Persson and Ellard, 2017; Philpot *et al.*, 2018). An international community-led campaign aims to raise awareness of TasP as a way to empower people living with HIV, to tackle HIV stigma, under the banner of U=U (‘undetectable equals untransmittable’) (Prevention Access

Campaign, 2017).

Goffman (1963) highlights the importance of notions of normality in both creating and resisting stigma. Socially established norms define those who fit inside or outside accepted categories, with stigma associated with attributes that fall outside. Research with serodiscordant couples has shown that treatment underpins a sense of normality and sameness with other couples and thus may be key in addressing the experience stigma (Hughes, 2017; Koester, Erguera and Myers, 2017). However, normalised discourses of HIV do not go uncontested and stigmatising tropes still dominate broader social discourse (Walker, 2019). Thus people in serodiscordant relationships often remain silent about their circumstances in order to avoid stigma (Persson, 2008). Contemporary serodiscordant relationships occupy a space between normalising and stigmatising discourses, with partners drawing on these and their own experiences to articulate new ways of ‘doing’ serodiscordant intimacy (Persson, Newman and Ellard, 2017). As I discovered, in the context of an ongoing processes of normalisation and continued stigmatisation, sensitivity can emerge in unexpected and novel ways.

Nothing to see here: An initial encounter with ‘normal’ sensitivity

My first encounter with sensitivity occurred before I had recruited a single participant and before the study had received institutional ethical approval. Though I was in the process of preparing an ethics application that outlined the potentially sensitive nature of the interviews I was planning, focusing on ‘traditionally’ sensitive aspects such as the examination of relationship intimacy and a stigmatised health condition, or the potential ethical implications of interviewing couples together and apart. However, I had not considered that the research question itself would give rise to sensitivity. There is a large body of research on HIV and relationships, with

serodiscordant relationships forming a significant proportion of this literature and I was confident that the project I had developed was academically and ethically sound. However, a chance encounter with someone who could have been eligible to participate in the research vividly brought that possibility to life.

I was at a friend's birthday party enthusiastically talking with some people I had met for the first time that evening about the focus of my research on serodiscordant relationships and how interesting I found the topic. As I was talking, I noticed another partygoer on the periphery of our conversation, arms folded, stern faced; a stark contrast to the others. "There's nothing interesting about our relationship, I don't know why you need to do a study. My boyfriend is positive, he's on treatment and that's it. Our relationship is normal," he said. Despite me agreeing and explaining that my motivation for doing the research was to describe the reality – and normality – of serodiscordant relationships, his hostility remained.
Research diary extract

Reflecting on this experience, I felt sheepish. In my enthusiasm for the subject I was concerned that I had inadvertently used stigmatising language. I worried that, as someone who was not in a serodiscordant relationship myself, my interest in the subject was illegitimate. Although I reassured myself that these concerns were unfounded, I could not fully answer the potential participant's charge that by selecting serodiscordancy as something worthy of study, I was problematising the relationships I sought to examine. I felt confronted by the naivety of my assumption that men in serodiscordant relationships would have no reason not to take part in my research. I had not considered that participants might object to the idea that their relationships were legitimate objects of study. In the context of a stigmatised condition such as HIV, notions of normality become entwined with discourses of stigmatisation and de-stigmatisation (Hughes, 2017). My research could potentially upset this balance and, in doing so, re-enact the social stigma potential participants were resisting. Lee (1993) also highlights how becoming the subject of research can itself be stigmatising, which he attributes to the traditional interest of sociology in the non-normative and the

‘underdog’. This experience began a process of reflection on, and navigation through, ambivalence about the normality (or otherwise) of HIV at the core of discourses of normalisation that were central to my enquiry, in dialogue with institutionalised understandings of sensitivity and research ethics, which I will explore in further detail here.

Investigating a ‘new normal’?

The first impact of the experience highlighted above was on my framing of the research and my approach to recruiting for the study. Although sampling participants from a particular population can be time consuming (Boynton, 2017), after an initial call yielded no responses at all, my initial concerns about potential participants’ resistance towards participating in my research were compounded. Various guides and guidelines (Lee, 1993; Dickson-Swift, James and Liamputtong, 2008; The British Psychological Society, 2014) stress the importance of respecting participants’ autonomy, making research voluntary and ensuring participants understand their right not to take part in research. But while these guidelines recognize that people who could take part may choose not to, they do not provide guidance on the potential range of meanings attached to **not** taking part for participants and how researchers should respond to non-participation. Although a lack of participation could be explained by an ineffective recruitment strategy that did not reach participants, non-participation in an activity can also be conceived of as an act of resistance (Scott, 2018). The recent experience of a hostile reaction from a potential participant loomed large and this explanation was at forefront of my mind.

In response to an imagined participant who was reluctant to become involved in a study that might be embedded in ‘old’ stigmatizing narratives of HIV, I focused my recruitment materials on the change and progress in HIV treatments and HIV prevention, and emphasised the need for research to reflect this new situation (extract

below). However, attempting to avoid sensitivity and stigma by writing the recruitment materials this way firmly allied the study with ‘normalised’ and ‘normalising’ discourses of HIV.

[Insert Figure 1 here]

In addition to a focus on the ‘changed world’ of serodiscordancy in recruitment materials, I pre-empted concerns that the aim of the research was aligned with potentially stigmatising discourses of serodiscordancy and risk. In materials I drew on biomedical developments and their influence on transmission risk in order to ally my research with the discourses of normality and the non-threatening nature of serodiscordancy.

Why are you doing this research?

A lot of research into mixed-HIV-status relationships has focused on sex and risk before the role that treatment can play in preventing transmission was fully understood. ‘Treatment as prevention’ provides an opportunity to look again at this subject, but also to move away from looking at risk alone and to consider the broader experience of being in a relationship.

Figure 2: Participant briefing sheet extract

Reflecting on these materials later in the research process, I recognised that although my motivation for communicating my research in this way was primarily a pragmatic response to a perceived distrust or suspicion in my project and an attempt to manage or mitigate sensitivity, it also led to me adopting a very visible position within a process of social change which I hoped to study through the research. While locating myself within a social constructivist ontology which eschews the concept of objective

or unbiased positions, I later became concerned whether emphasising one position, while attempting to examine experiences from a range of alternative positions, closed down rather than opened up the focus of my enquiry: did couching my research within normalizing discourses imply an invitation for positive stories of relationships in which HIV was not an issue? Would this potentially alienate those for whom this did not ring true and make them less likely to participate in the research?

Navigating potential stigma

Whether or not it was due to the new strategies I deployed above, ultimately, this recruitment approach was successful, and I was able to interview a number of participants. The next way in which I reflected that the navigating the (ab)normal sensitivities of this research influenced the conduct of the research was during the interviews themselves. Bringing to mind the hostility I experienced early on in the research process, even despite piloting the interview schedule to check it was appropriate and acceptable, I became sensitized to suggesting that serodiscordancy was not normal. This led me to approach the question of its relevance in an indirect way during interviews.

Although a focus on the everyday was theoretically and methodologically justified in my research, when I explained this to participants, this often served as an opportunity for me to stress that I wasn't '*just interested in HIV.*' This further reinforced to participants my focus on serodiscordancy as something part of the everyday and thus 'normal.' Consistent with this approach, I constructed the interview schedule to ask questions about serodiscordancy in the context of a broader understanding of participants' everyday relationship experiences. In line with advice for developing questions for a semi-structured interview, I wrote a series of open questions through which I aimed to prompt participants to describe their experiences. However, on

reviewing the recordings and transcripts from the interviews, as well as my own reflection on the experience of conducting the interviews, I noticed I departed from the question construction in the guide when it came to asking participants about their experiences of serodiscordancy, instead deploying phrasing which suggested an ambivalence towards the relevance of HIV to their relationship.

[Interviewer] Erm, and so we've talked about a few, kind of, factors that influence your relationship, or make it what it is. I kind of have to ask, what role does HIV play in your relationship, if anything?

Individual interview 14-01

I reflected that this phrasing helped me demonstrate to participants that I did not automatically assume that HIV was important in the everyday experience of a serodiscordant relationship. Although framing the question in this way departed from general advice in the literature for researchers to ask open questions in order to allow participants to take the lead in the flow of the interview, it allowed me to position myself as open to a negative response. In addition to constructing the question to highlight the potential irrelevance of serodiscordancy, in order to remove potential sensitivity from the research encounter I also introduced a rhetorical distance between myself as the embodied interviewer asking the questions, and the (distant) creator of the interview schedule, '*I have to ask.*' In later interviews, I increased this distance, bringing in an additional party to the interviewer-participant dynamic, the university. In presenting the institution as not just a passive supporter of research but a powerful governor of its conduct and my employer, I foregrounded obligations often invisible during research encounters in order to minimise my agency in the conduct of the interview.

[Interviewer] So the idea with these [questions] is, there's some general topics,

there might be some stuff that you've got to say about them, there might not be. [...] I think the ones that I'm definitely going to point to, if you don't, are probably 'low points', 'high points' and... and if we don't talk about HIV I'll probably get sacked from my studentship!

Couple interview-06

Joking with participants that I was obliged to ask about HIV in order to keep my job, signalled my ambivalence while retaining it as a topic of discussion in the couple interview. Although the participants in this instance laughed with me, even in jest I presented that the reason the topic was important was not because of its relevance to the research, but because of a need to satisfy the institutional requirements. Although the phrasing of these questions could be analysed as poor interview technique, or verging on deception of participants, I reflected that in the context of the interview as a social encounter these were techniques which helped to maintain rapport with participants, many of whom had already spoken about how little HIV featured in their day-to-day relationship. These rhetorical 'fig leaves' that I adopted during the research process further helped me position myself as a sympathetic researcher who was sensitive to the idea that viewing serodiscordancy as non-normative was linked to stigmatizing discourses of HIV. Adopting the view of the interview as a social interaction and applying Goffman's analysis of the management of identity (1963) emphasises the importance of creating 'normality' through the interaction in order to manage stigma. The importance of these strategies was further emphasized when I began to analyse interview data, in which the contested nature of normality was a key factor for participants in relation to how they talked about their relationship with others (Author, *in preparation*). The idea of serodiscordancy being a normal, untroubled state was underpinned in participants' accounts by biomedical discourses which construct HIV as rendered unthreatening or irrelevant by antiretroviral treatment. Whether others were already familiar with, or were open to, these ideas was a key factor for many

participants in deciding whether to discuss their serodiscordancy or whether to remain silent and avoid the potential HIV stigma arising from ‘ignorance’. Thus navigating the contested nature of ‘normality’ in the context of serodiscordancy appeared to be a crucial consideration for participants, and underscored the importance of my drawing on and emphasizing discourses of normality in presenting the research to potential participants and throughout the research process.

Discussion

In this article, I have explored how unexpected sensitivity emerged during a research project in relation to issues of ‘normality.’ I have argued that it centres on the position of serodiscordant relationships in relation to discursive tensions generated by discourses of normalization of HIV, rather than being related to the ‘sensitive’ subject of HIV and relationships itself. My experience of the research, first becoming aware of an unexpected sensitivity, consciously and unconsciously managing it during the research and reflecting on it during analysis, has led to my understanding of the crucial role that ideas of normality play in creating and counteracting stigma and thus in creating or diminishing sensitivity. I have speculated whether my response to manage the emergent sensitivity had an influence on participation in my research and therefore led to a more homogeneous sample of experience. Looking beyond the specific context of this research, the issues I have discussed here may be relevant for researchers active in settings or subject areas where discourses of normality are deployed to claim equality for or the validity of stigmatised identities, such as Muslim identity among teenagers in Australia (Harris and Karimshah, 2019). However, in exploring my responses to the emergent and dynamic sensitivity, I am not suggesting that I am providing a blueprint of techniques to manage such research. Instead, I am highlighting the importance of both personal and epistemological reflexivity (Finlay, 2011; Braun and Clarke, 2019) on the part of the researcher with regard to the way in which competing discourses of normal/not-normal are occupied and articulated during each stage of the research

process. This paper draws attention to how sensitivity can infuse the whole research process, including not only recruitment but in influencing the conduct of fieldwork, (even down to the phrasing of individual questions during interviews).

Claims to normality are often a feature of arguments for equal treatment of minority sexualities and have been deployed in narratives about gay and lesbian foster carers (Hicks, 2005) and are central to discourses concerning the validity of same-sex relationships (Heaphy, 2018). Outside of the realm of sexuality, claims to normality have been used by immigrants of minority ethnicities to resist othering (Jensen SQ, 2011; Harris and Karimshah, 2019). Punch (1994) argues that critical researchers aiming to do ethical work must do more than simply respect their participants or treat them with courtesy; they should actively work to elucidate imbalances of power and work towards eliminating them. While I share a commitment to empowering participants through research (Tisdale, 2004) and recognise that enabling participants to share their stories in their own words can play an important part in shaping norms and addressing stigma (Plummer, 1995; Persson, Ellard and Newman, 2016), the experience of this project has highlighted the embeddedness of the researcher within the social power relations. A commitment to empowerment or the benign intent of an individual researcher cannot on its own address or compensate for wider social processes of stigmatisation and normalisation. This stresses the importance of engaging with sensitivity beyond ‘tick box’ definition within ethics applications, and highlights the need to be attuned to participants’ concerns about all aspects of the research, up to and including the research question itself. Furthermore, by approaching sensitivity as an emergent phenomenon that is interpreted differently by institutional ethics committees, researchers and – importantly – participants this analysis foregrounds the power inherent in defining and ‘fixing’ definitions of sensitivity. It also demonstrates how formal definitions of sensitivity are navigated, negotiated and resisted in practice. This

highlights how concepts of ‘sensitive’ and ‘normal’ are not mutually exclusive binaries but can co-exist as lenses through which to better understand lived experience (Hathaway, Comeau and Erickson, 2011).

In the context of normalized or normalizing phenomena, it underlines the importance of reflection on and engagement with the discourses of normality that participants are negotiating in and, in particular, the relevance of these to issues of stigma. Although it is important that researchers retain their freedom to critique both stigmatising and normalising discourses, it is also important to consider the dynamics of power relations and stigma in deploying criticism of normalisation, whether they intend it or not.

More broadly, the issues discussed here point to a methodological tension between the way in which researchers and ethics committees construct their participants and the way in which participants construct themselves. As well as the stigmatising potential of being researched itself, Lee points to the role that implicit assumptions about research play in the potential for divergent interpretations to arise between the researcher and researched; a study seen as problematic by one group can be thought innocuous by another (Lee, 1993, p. 5). However, drawing on Goffman (1963) and the importance of the presentation of ‘normality’ in avoiding stigma, illustrates how research that positions participants as outside normative bounds has the potential to generate stigma. This is often most immediately obvious in studies engaged with ‘sensitive’ topics, but could arise in any study in which questions of normality are at stake. This disrupts ‘static’ approaches to understanding sensitivity in the research process traditionally used in ethical assessment and highlights the need for a more nuanced and reflexive approach to assessing and managing sensitivity throughout the research process.

[3810 words, including abstract]

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Figures

HIV has changed.

**We know that treatment makes it possible to live well
with the virus without passing it on.**

This has transformed how HIV is treated and prevented.

**But what does it mean for men living with the virus and
their partners?**

Figure 1: Recruitment postcard extract

Appendix H: Accepted conference abstracts

Centre for Research on Families and Relationships conference 22-24 June 2020

“It’s not a big deal.” Gay men’s reframing of serodiscordant intimacy in the era of treatment as prevention

Mixed HIV status (serodiscordant) relationships have been constructed by public health discourses as key sites of viral transmission and risk. With the advent of ‘treatment as prevention’ (TasP), which antiretroviral treatments have been shown to prevent HIV transmission, focus has shifted from regulation of intimate behaviours to biomedical prevention. As well as a public health project, TasP is currently at the centre of an HIV community led campaign to tackle stigma by reframing HIV positive people on treatment as uninfected. In the midst of this biomedical transformation of HIV risk, serodiscordant couples are engaged in repurposing the biomedical technology of TasP in order to contest risk-centric conceptions of serodiscordancy realise new forms of serodiscordant intimacy (Persson 2017). This paper will discuss the findings of a qualitative study of the lived experience of gay men in same-sex serodiscordant relationships. Individual (n=28) and couple interviews (n=6) generated data which were analysed with a particular focus on practices of intimacy. Through engaging with the everyday, it will examine how participants drew on the concept of TasP to create a sense of normality and the everyday absence of HIV in their relationship, as well as incorporating the biomedical into intimate practices of care. It will also consider how they used TasP and the relationality of serodiscordancy to resist individualised, condom-centric public health discourses of ‘safer sex’ and reframed as ‘safe’ sexual practices that had previously constructed as ‘unsafe’. Finally, by engaging with theories of ‘emotion work’ (Hochschild, 2012) and ‘hauntology’ (Derrida, 1994) it will examine how, despite its everyday absence, the virus and stigma played a subtle but important role in shaping participants’ experiences of serodiscordancy.

"It's almost like it isn't there" Experiences of same-sex serodiscordant intimacy in the era of treatment as prevention

T Witney, P Keogh, The Open University, Milton Keynes, UK

Largely invisible in epidemiological descriptions of HIV, serodiscordant relationships have nevertheless occupied a central position in pre-‘treatment as prevention’ (TasP) public health discourses as key sites of transmission risk, deserving attention and intervention. With the advent of TasP, focus has shifted from regulation of intimate behaviours to biomedical mechanisms to achieve an undetectable viral load. Serodiscordant couples are themselves engaged in this repurposing of HIV treatments for prevention: Persson and colleagues have described how serodiscordant couples are imagining and realising new forms of intimacy. This research aims to understand the changing meanings of HIV, risk and intimacy in male same-sex serodiscordant relationships. Understanding how these biomedical developments impinge on, and are themselves influenced by, the lives of serodiscordant couples has implications for the efficacy of future prevention.

This paper will discuss the findings of a qualitative investigation of the lived experience of men in same-sex serodiscordant relationships in the UK, with a particular focus on everyday practices of intimacy within the context of biomedicalisation. Purposive sampling was employed to recruit 30 HIV positive and HIV negative men who had a different status to their partner with a focus on date of positive partner’s diagnosis aligned with key milestones in antiretroviral treatment (pre-1996, 1997–2010 and from 2011). Participants were interviewed individually, and 6 couples participated in a second interview together. Data were analysed using hermeneutic phenomenological analysis.

Is this safe? Does it matter? Reframing same-sex serodiscordant intimacy in the era of 'treatment as prevention'

T. Witney, The Open University, Milton Keynes, UK

Mixed HIV status (serodiscordant) relationships have occupied a central position in public health discourses as key sites of transmission risk. With the advent of 'treatment as prevention' (TasP), focus has shifted from regulation of intimate behaviours to biomedical prevention. Serodiscordant couples are themselves engaged in this repurposing of HIV treatment, with couples imagining and realising new forms of intimacy. This paper will explore the changing meanings of HIV and risk in male same-sex serodiscordant relationships. Biomedical developments impinge on and are themselves influenced by the lives of serodiscordant couples. Understanding 'everyday serodiscordant behaviours' has implications, therefore, for the efficacy of future prevention. This paper will discuss initial findings of a qualitative investigation of the lived experience of gay/bisexual men (n=26) in serodiscordant relationships in the UK, with a focus on everyday practices of intimacy.

Adopting Plummer's concept of intimate citizenship, analysis focuses on the interface of the 'public/private' in participants' discussion of their relationship. Against a background of a condom-centric "safer sex" discourse, participants struggle to renegotiate the risks of condomless sex in the presence of TasP. Conversely, TasP has pushed HIV out of the everyday, transforming both experiences of serodiscordancy and the ethics of serodiscordant sexual citizenship. This paper draws on the emerging sociology of 'nothing' to investigate where and in what ways the virus continues to play an important role in shaping relationship practice – despite its 'absence'.

Keywords: HIV, intimacy, biomedicalisation

Is this safe? Does it matter? Reframing same-sex serodiscordant intimacy in the era of treatment as prevention

T Witney, P Keogh, The Open University, Milton Keynes, UK

Background

Largely invisible in epidemiological descriptions of HIV, serodiscordant relationships have nevertheless occupied a central position in pre-‘treatment as prevention’ (TasP) public health discourses as key sites of transmission risk, deserving urgent attention and intervention. With the advent of TasP, focus has shifted from regulation of intimate behaviours to biomedical mechanisms to achieve an undetectable viral load.

Serodiscordant couples are themselves engaged in this repurposing of HIV treatments for prevention: Persson and colleagues have described how serodiscordant couples are imagining and realising new forms of intimacy. This research aims to understand the changing meanings of HIV and risk in male same-sex serodiscordant relationships. Understanding how these biomedical developments impinge on, and are themselves influenced by, the lives of serodiscordant couples has implications for the efficacy of future prevention.

Methods

This paper will discuss the initial findings of a qualitative investigation of the lived experience of men in same-sex serodiscordant relationships in the UK, with a particular focus on everyday practices of intimacy within the context of biomedicalisation.

Purposive sampling was employed to recruit 26 HIV positive and HIV negative men who had a different status to their partner with a focus on date of positive partner’s diagnosis aligned with key milestones in antiretroviral treatment (pre-1996, 1997–2010 and from 2011). Data were analysed using hermeneutic phenomenological analysis.

Results

Adopting Plummer’s concept of intimate citizenship, analysis focused on the interface of the public/private in participants’ discussion of their relationship intimacy. Against a background of an individualised, condom-centric “safer sex” public health discourse, participants struggle to renegotiate the risks of condomless sex in the presence of TasP. Participants’ accounts describe a scene where, to a greater or lesser extent, TasP has pushed HIV out of the everyday, transforming experiences of serodiscordancy. Drawing on the emerging sociology of ‘nothing’ illuminates where, despite its ‘absence’, the virus continues to play an important role.

Implications

These accounts of serodiscordancy show how TasP troubles established notions of risk and safety in both intimate and public life. In doing so, this social-biomedical technology blurs the serostatus binary and associated discourses of responsibility in the broader context of HIV sexual citizenship.

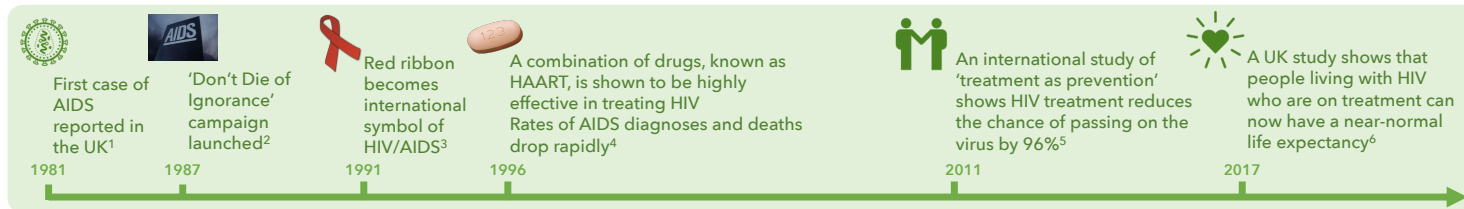
YOU+ME Time to look again at HIV and relationships

Tom Witney, Faculty of Wellbeing, Education and Language Studies, The Open University. Supervisors: Dr Peter Keogh, Prof Jacqui Gabb, Prof Darren Langdridge

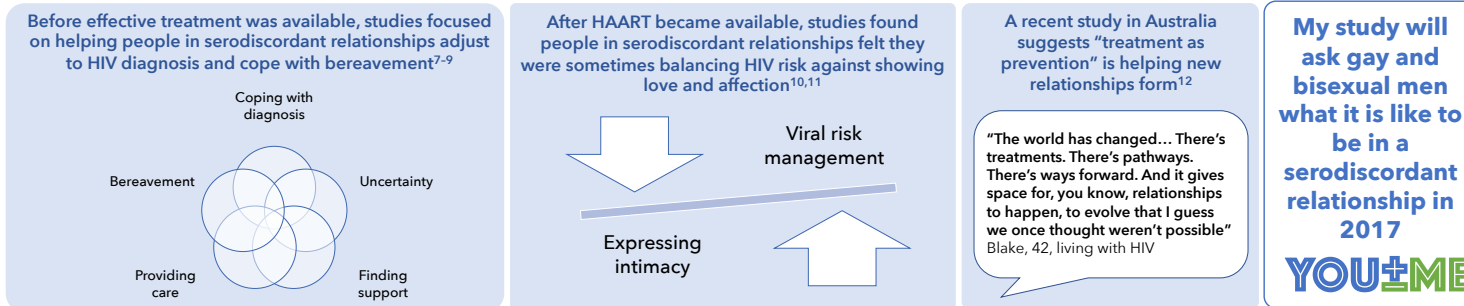
Summary

It is over 30 years since the human immunodeficiency virus (HIV) epidemic began in the UK. Although its stigma remains, these days many people live well with HIV. Recently it has been shown HIV treatments can help stop the virus being passed on. This is already changing how doctors treat HIV, but few studies have looked into how this might affect HIV positive and HIV negative people's relationships. This study will focus on the experiences of gay and bisexual men in relationships who have different HIV statuses to each other (known as serodiscordant relationships) in order to understand what it is like, how they make their relationship work, and where HIV treatment plays a role

HIV has been transformed over the last 30 years



Life for people in serodiscordant relationships has also changed over time



Key terms

AIDS: Acquired Immunodeficiency Syndrome, a group of illnesses that occur when HIV has severely reduced someone's immune system
HAART: Highly active antiretroviral treatment, medicines which act together to stop HIV multiplying and keep people living with the virus well
HIV: Human immunodeficiency virus, a virus that can be transmitted through blood, during sex and through breastfeeding. There are few symptoms of being HIV positive, but it attacks key cells in the immune system, meaning that if it is not treated people gradually become unwell
Serodiscordant: A term that means 'antibodies do not match', used to refer to relationships where partners have different HIV statuses
Treatment as prevention: as well as keeping people living with the virus healthy, HIV treatment can stop the virus being passed on

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